

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Hon. Alison R. Lee, Circuit Court Judge

Case No. 2011-CP-40-03561

RECEIVED

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SC Court of Appeals

Gertrude Shiver,.....Claimant, Appellant,

v.

Palmetto Health Richland, Employer,
Key Risk Management Services, Inc., TPA
Palmetto Hospital Trust Services, Carrier,
Trident Regional Medical Center, Employer,
Zurich American Insurance Company, Carrier,.....Respondents,

RECORD ON APPEAL
VOLUME III

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/29/02

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, reflux with overlapping stricture status post dilation and chronic back and neck pain, who basically presents with significant left neck and shoulder discomfort status post trauma. The patient claims that she was sitting at her desk at work when a heavy medical chart fell off of a cart and struck her in the left shoulder. She had a significant amount of discomfort almost immediately and was evaluated in the Emergency Room. Exam at that time revealed what was felt to be a trapezius strain. She was placed on Darvocet and Flexeril. The patient notes that the Flexeril did cause a moderate amount of sedation and has not necessarily been compliant with that. The Darvocet has helped somewhat with the discomfort. Due to the fact that it has not completely resolved, she claims that she felt that she needed to seek further medical attention. The trauma occurred on 10/24/02 and she was evaluated in Richland's ER that evening.

Supervisor
dropped
chart on
neck
& shoulder
left side
heavy thick
chart

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.
ALLERGIES: Unchanged as previously documented in the chart.
MEDICATIONS: Unchanged as previously documented in the chart.
SOCIAL HISTORY: Unchanged as previously documented in the chart.
FAMILY HISTORY: Unchanged as previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Aciphex 20mg q day
4. Mobic 7.5mg bid
5. Skelaxin prn, which is rare
6. Occasional Green Tea
7. Occasional Tylenol
8. Baby aspirin daily
9. Serevent metered dose inhaler prn, which is rare
10. Currently Darvocet N 100 prn
11. Flexeril prn

REVIEW OF SYSTEMS: The patient notes full range of motion. She claims that it has been slightly difficult for her to sleep due to discomfort. She notes that it has improved a moderate amount but still it is not back to normal. She reminds me that she has problems with her neck and spine. All other systems reviewed at this time and negative.

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/29/02

PAGE 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Moderately anxious, in no acute distress.

HEENT: Unremarkable.

NECK: There is moderate left-sided cervical spinous tenderness with muscular spasm that radiates into the entire left neck and left deltoid region.

LUNGS: Clear.

CARDIOVASCULAR: Regular.

ABDOMEN: Benign.

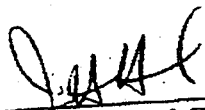
EXTREMITIES: No edema.

MUSCULOSKELETAL: The patient has full range of motion of the left shoulder. With full extension of the left shoulder, the patient does slightly exacerbate pain.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Left trapezius strain. Again, the patient was told that she needs to rest this arm. She was told to avoid heavy lifting for the next five days. She was told to use conservative measures such as heat, rest, and we will continue with her Darvocet. She will take Skelaxin during the day as this should cause less in the way of sedation and take Flexeril at night. She can continue with her Mobic and take Darvocet through any breakthrough pain. The patient was reassured that it was very unlikely that a chart itself has caused any bony damage but if she fails to resolve, we will have her go back to Charleston to the Spine Institute where she is followed closely.
2. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
3. Reflux. Asymptomatic on Aciphex.
4. Colon polyp. See previous dictations.



Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/06/02

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, reflux with overlapping stricture status post dilation and chronic back and neck pain, who basically presents with continued neck discomfort. The patient, as previously dictated on 10/29/02, had a medical chart fall on her left neck. She was immediately seen in the Emergency Department, where it was determined that she had a cervical strain. She was given some Darvocet and Flexeril, which did seem to help. However, since the symptoms persisted, she came here on 10/29/02. She noted that she continued to have problems with left neck and shoulder discomfort. There was a moderate amount of muscular tightness on exam and thus she was given Skelaxin so she could take it during the day as it is more non-sedating and she could continue with Flexeril as needed. She was kept on her anti-inflammatories and given a few more Darvocet. The patient notes that this pain has persisted. She claims that when the medications wear off, she immediately is in a moderate amount of discomfort. She claims that it has affected her ability to work. She otherwise has no other complaints.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.
ALLERGIES: Unchanged as previously documented in the chart.
MEDICATIONS: Unchanged as previously documented in the chart.
SOCIAL HISTORY: Unchanged as previously documented in the chart.
FAMILY HISTORY: Unchanged as previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Tenormin 25mg bid
2. Aciphex 20mg q day
3. Mobic 7.5mg bid
4. Darvocet N prn
5. Skelaxin prn
6. Flexeril prn
7. Occasional Green Tea
8. Baby aspirin daily
9. Occasional Tylenol

REVIEW OF SYSTEMS: The patient has discontinued her Cardizem. Basically her blood pressure was on the low side and she stopped this on her own. She has continued with the Tenormin. Fortunately, she has been palpitation free as this has been a significant problem for her in the past with documented paroxysmal supraventricular

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/06/02

PAGE 2

REVIEW OF SYSTEMS: (cont.)

tachycardia. I have once again told her that we were using the Cardizem and the Tenormin not necessarily for blood pressure control but for rate control. She understands this and realizes that we may have to put her back on Cardizem despite having relatively low blood pressure at 90/60. She was asymptomatic in regards to lightheadedness, near syncope, etc. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Moderately anxious, in no acute distress.

HEENT: Unremarkable.

NECK: Some left-sided muscular tension, otherwise, unremarkable.

LUNGS: Clear.

CARDIOVASCULAR: Regular.

ABDOMEN: Benign.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Cervical strain/trapezius strain. Will send the patient for physical therapy. She does have an appointment with The Spine Clinic in Charleston coming up in the near future. She was told to make them aware of her condition. Again, I am surprised that something as minimal as a chart falling on her neck would cause this much problem. Hopefully physical therapy will be able to help her tremendously. She will continue her current medical regimen on an as needed basis.
2. Paroxysmal supraventricular tachycardia. Again, has been asymptomatic since discontinuation of her Cardizem due to hypotension. We will follow.
3. Past history of hypertension. Has not been a problem for quite some time. If anything, the patient has a tendency to be somewhat hypotensive. We will continue Tenormin at its current dose. She was told not to discontinue this or I am sure she would have breakthrough rebound tachycardia. We will follow in this regards.

White
Shiver is now dropped
Chart as 1st side
of neck shows dev. very
thick
Chart

(422)

MIDLANDS INTERNAL MEDICINE

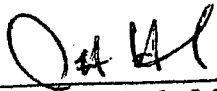
OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/06/02

PAGE 3

ASSESSMENT AND PLAN: (cont.)

4. Reflux. Stable on Aciphex.
5. Routine health maintenance. Basically up to date. The patient has already had her flu shot.



Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for complete physical exam. The patient notes that she is continuing to have a moderate amount of neck discomfort, which somewhat radiates into her left shoulder. This all occurred after a chart from the hospital dropped on her shoulder region. She has undergone physical therapy with very little in the way of improvement. She otherwise has no major complaints.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995

ALLERGIES:

1. Tetanus caused severe edema and induration with pain
2. CT dye gave her hives and palpitations.
3. PPD caused hives and palpitations as well.

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Mobic 7.5mg bid
4. Baby aspirin daily
5. Occasional Tylenol.
6. Skelaxin and Flexeril pm
7. Aciphex 20mg q day
8. Humibid LA bid

SOCIAL HISTORY: The patient does not smoke, nor does she use alcohol. She is not married and has no children. She is not sexually active. She is originally from Gaston and lived in Charleston but has been in Columbia since 1998. She was a cardiac nurse but became disabled due to back pain. She now works in Medical Records for Richland Memorial Hospital and does note a moderate amount of stress.

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MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03

PAGE 2 of 3

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90. She had diabetes, dementia, and actually had a stroke in the end as well. She denies any significant heart disease in the family but does note hypertension and strokes. She also notes diabetes as well as breast cancer. She had a sister in her 50's that was recently diagnosed with colon cancer. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is poor. Her exercise is minimal.

REVIEW OF SYSTEMS: The patient continues to get occasional headaches. These, if anything have somewhat improved. She has her eyes checked regularly. She does note occasional mild dysphagia but this has improved with Aciphex and is not to the point where she needs repeat dilation. She notes occasional nauseated episodes but cannot give any further details in this regards. She denies any significant palpitations as of recent and has done well on her current regimen. She notes, again, diffuse pain in her neck and shoulder region as well as her lower back. She also continues to have some problems with abdominal discomfort but has had normal CT scan of the abdomen and pelvis as of recent. She notes a lesion on her left big toe that she would like to have removed. She really has no other major complaints, other than that of moderate fatigue. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round and reactive to light and accommodation. Extra-ocular movements intact. Funduscopic exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No lymphadenopathy. No thyromegaly. No bruits.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. There are no murmurs, rubs, or gallops.

ABDOMEN: Soft, nontender, nondistended. There are positive bowel sounds in all quadrants. There is no hepatosplenomegaly or mass.

BREASTS: No palpable masses. Mild fibrocystic changes. No nipple inversion. No skin dimpling.

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**MIDLANDS INTERNAL MEDICINE
PHYSICAL EXAMINATION**

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03
PAGE 3 of 3

PHYSICAL EXAMINATION: (cont.)

UROGENITAL: The patient has normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable.

RECTAL: No masses. Normal sphincter tone. Guaiac negative stool.

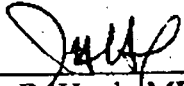
EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS: EKG was obtained and reveals a sinus bradycardia and nonspecific STT wave abnormalities, otherwise unchanged from prior tracings.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Extremely well controlled with current regimen, on Cardizem CD and Tenormin. Will continue with this regimen.
2. Reflux with overlapping stricture, status post dilation. Has improved with Aciphex. Will continue.
3. Adenomatous polyp. The patient had colonoscopy performed in May, 2002, which revealed a tubular adenoma. She will have repeat colonoscopy in two years.
4. Hoarseness. Had been a complaint. The patient went to see ENT, who basically claimed the patient had muscle tension dysphonia. She did have fiber optic exam, which basically was unremarkable. The patient was given speech therapy and Humibid LA. She claims that she was not completely satisfied with her evaluation.
5. Neck pain. Will send back to Charleston Spine Institute, which the patient has been followed there closely.
6. Chronic back pain. Again, followed by the Spine Institute. We will switch her Mobic over to Bextra, which hopefully will give her more relief.
7. Abdominal discomfort. The patient continues to have mild tenderness in the left upper and left lower quadrant, radiating to the suprapubic area. Again, there are no significant findings here. We will continue to follow. The patient was reassured in regards to a normal CT scan.
8. Lesion, left big toe. It appears that the patient has a small cyst on her left great toe tendon sheath. She was reassured.
9. Routine health maintenance. Have gotten the patient completely up to date. We will continue to follow closely.


Jeffrey D. Hook, MD

(426)

RECEIVED

MAR 17 2003

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FELLOWS, AMERICAN ACADEMY OF OTOLARYNGOLOGY
HEAD AND NECK SURGERY

Otolaryngology
Pediatric Otolaryngology
Head & Neck Surgery

Rhinology
Sinus Disease
Laryngology

Otology
Audiology
Hearing Aids

PATIENT: GERTRUDE SHIVER

DATE: 4 MARCH 2003

ALLERGIES: SEE CHART

TO: DR. JEFFREY HOOKS

*noted
Tm
02/20/03*

The patient is a 48-year-old female who presents to the office stating that she noted around Christmas Day that she was very hoarse and could only whisper, which lasted until the second week of February. When this initially started, she noted a little scratchy throat, but that resolved. She also noted a little coughing, which has essentially resolved. She has not been noting any nasal symptoms. Patient feels that although her voice is much better, it is not clear, and she sings in the choir, and will note some muscle pain and strain when talking and singing. She occasionally feels like it hurts to swallow, but foods and liquids go down all right. She does give a ten-year history of GERD, but feels that has not really been bothering her lately. Patient did see her physician and was given a Z-Pak in December, followed by some Levaquin in January, and more recently was given some Clarinex which did not seem to help. She denies tobacco use. No ear complaints.

PMH/ROS: Self-filled out medical history sheet was reviewed with the patient.

CURRENT MEDICATIONS: Tenormin, Cardizem CD, Ultram, Mobic, Aciphex, Skelaxin, and one 81 mg aspirin daily.

DRUG ALLERGIES: See chart.

PE: Well-developed, well-nourished, black female, in no acute distress. Patient seems to communicate well at normal conversational speech levels. Voice objectively to me does not sound particularly hoarse, weak or breathy. Examination of the ears negative. Examination of the nose reveals the mucous membranes to appear in good condition without discharge. Examination of the oral cavity, oropharynx and neck negative. Patient with gagging to mirror examination. No obvious lesions of the nasopharynx or hypopharynx. Larynx not well seen. No tenderness to palpation over the sinuses. Facial motion appears intact.

Under P&L solution, the fiberoptic scope was inserted through the right nostril, which looked good, as did the nasopharynx, base of tongue, vallecula, epiglottis, hypopharynx, pyriform sinuses, endolarynx, and immediate subglottic area. Vocal cord mucosa appears in good condition. Vocal cord motion appeared good on a number of phonatory tasks.

IMPRESSION: 1) Hoarseness probably secondary to muscle tension dysphonia.

DISPOSITION: Will have the patient evaluated by a speech therapist and go from there.

JACQUELYN A. GOING, M.D./lsb

(427)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

May 13, 2003\ Patient is seen in follow up has failed to show any significant benefit to the PT and appropriate medications given by Dr. Hook. Dr. Hook has now discontinued Mobic and has started patient on Bextra on trial basis, pending further treatment here. See medication section for other details.

Patient has come in today for consideration for possible trigger point/focal injections left neck/shoulder.

Medications: Patient is currently taking alprazolam (Xanax 0.5 mg) prn for anxiety, this prescribed by Dr. Hook. Patient recently started on Bextra, no change in pain as yet with this new medication.

Physical Examination: Reveals significant trigger points left supraspinatus mid-belly, left levator scapulae, and left upper trapezius, but also significant trigger points left posterior and anterior scalene and left splenius cervicis as well as capitis muscles usual sites. Marked tenderness also noted over left C2-3 through C6-7 cervical facets to varying degrees, most significant tenderness at upper four cervical levels. Left greater than right greater occipital nerve route tenderness also noted.

Impression: 1. Flared/recurrent cervicothoracic myofascial and/or facet-generated pain (left sided cervical and upper shoulder strain syndrome (S/P work-related neck and shoulder contusion, unresponsive to prior conservative measures (Dr. Hook)).
2. Persistent left sided cervical facet syndrome with significant myofascial pain component, symptomatic/flared S/P work-related contusion to left neck and shoulder 10/24/02 by history (with history of chronic myofascial/facet-generated pain and underlying/pre-existent C4-5/C5-6 cervical spondylosis, initially symptomatic S/P MVA 4/20/97, flared with work injury 10/11/97, also flared more recently with significant recurrence following MVA 11/25/00).
3. Chronic (but currently stable) low back pain with underlying discogenic, facet-generated, and myofascial pain components, recently flared/symptomatic S/P work-related fall from chair 3/23/02, stable following recent series of blocks (with known L4-5 and L5-S1 symptomatic annular tear/protrusions, previously stable, initially symptomatic S/P work-related MVA 10/11/97, flared/worsened S/P MVA 11/25/00).

Recommendations/Discussion: Patient is candidate for focal injection therapy left shoulder and neck region. She is really the classic "egg-shell" patient in that she has had multiple injuries in past, and even minor injuries to these regions can cause fairly significant flares in this patient. It is not atypical for these patient's to fail to respond to more conservative measures such as PT and medications (those measures that may be effective in less compromised patients), with this in mind, I have accomplished the following today.

1. Left C3-4 and C4-5 cervical facet blocks, 5 mg methylprednisolone acetate per site, sterile technique, non-fluoroscopic, 25 gauge 2" spinal needles used at each site.
2. Left lateral neck trigger point injections, left posterior scalene and left splenius cervicis muscles, 2.5 mg Aristospan per site, non-fluoroscopic, 27 gauge 1 1/4" spinal needle used at each site.
3. Left shoulder girdle trigger point injections, 2 sites (left supraspinatus and levator scapulae muscles), 2.5 mg Aristospan per site, sterile technique, non-fluoroscopic, 27 gauge 1 1/4" spinal needles used.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Follow up will be accomplished in several weeks. I have discussed option regarding use of further cervical facet injections (if necessary), based on response to two levels treated today, for any residual cervical symptoms relating to this underlying pathology. I have also discussed option regarding treatment of recalcitrant trigger points with Myobloc (botulinum toxin type B) if necessary.

At this point, patient remains neurologically stable, as assessed 4/23/03 regarding upper limbs. No need for any specific restrictions regarding vocational and/or avocational pursuits at this time, relating to cervical injuries sustained 10/24/02, to a reasonable degree of medical certainty.

Patient not yet considered at MMI regarding injuries sustained 10/24/02 on the job to left cervical and upper shoulder girdle region.

Gregory M. Jones, M. D.

GMJ/bjl

428
FAXED
5/13/03

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE

June 3, 2003 Patient is seen in follow up. Has fortunately shown good, but partial benefit to previous two level cervical facet and focal injections accomplished on last visit. This treatment ongoing relates to 10/24/02 work injury where object was dropped on her left neck and shoulder region while on the job. Patient has basically had flaring of facet-generated and myofascial pain. Pleased with partial benefit noted from injections accomplished last month, but still does not feel that she is back to pre-injury/baseline level in spite of good benefit noted. Patient here today for further focal injections as warranted. Has come in with driver. Is planning to stay overnight here in Charleston.

Physical Examination: Reveals fairly significant tenderness at left C2-3, C3-4, C4-5, C5-6, and C6-7 cervical facet regions to varying degrees. There is still moderate tenderness even over two facet levels previously treated utilizing 5 mg DepoMedrol per site. In addition, rather severe trigger points noted in left posterior and anterior scalene muscles as well as splenius cervicis and splenius capitis muscles usual sites. Severe trigger points also noted left upper shoulder girdle muscles, particularly left supraspinatus mid-belly and another trigger point in supraspinatus at distal portion of muscle just proximal to musculotendinous junction. Significant trigger points also noted left upper trapezius, left levator scapulae, and left proximal sternocleidomastoid, clavicular head. Additionally, there is moderate tenderness bilateral greater occipital nerves, approximately equal on today's exam. No treatment accomplished on right side, using this side as "control."

Impression: 1. Persistent/flared cervicothoracic/left upper shoulder girdle myofascial and facet-generated pain (chronic cervicothoracic/left shoulder girdle strain syndrome)-flaring noted since work-related injury 10/24/02, good benefit noted to recent focal injection therapies.

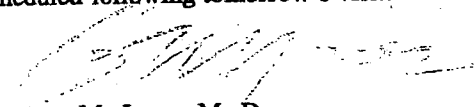
Recommendations/Discussion: Patient is not yet considered at MMI regarding flaring/worsening of symptoms relating to work injury 10/24/02, to a reasonable degree of medical certainty. Patient is candidate for continued focal injection therapy, based on good response noted to prior treatments on last visit in May. Patient is candidate for trial chemodenervation with botulinum toxin type B (Myobloc), as this should be quite effective for these recalcitrant and chronic (but flared) trigger points left shoulder girdle and left lateral neck region. Can likely treat most severe trigger points, and others should gradually clear once patient is able to return to more normal activities.

With this in mind, I have accomplished the following focal injections today:

1. Left C2-3, C3-4, C4-5, C5-6, and C6-7 cervical facet blocks, 5 mg methylprednisolone acetate per site, (except 10 mg DepoMedrol used at both left C3-4 and left C4-5 levels), sterile technique, non-fluoroscopic, 25 gauge 2" spinal needle used at each site.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Will work patient into schedule tomorrow morning, since she does have a driver and since she lives so far away from clinic. Can go ahead and schedule patient for left shoulder girdle and/or lateral neck trigger point chemodenervation with Myobloc (botulinum toxin type B). It is very likely that this treatment (utilizing no steroids) scheduled for tomorrow, along with today's treatment (utilizing low dose steroid) can likely give patient very good overall benefit, can possibly even get her back to baseline/pre-injury level in relation to flaring of symptoms since 10/24/02 work injury. No change in other recommendations as per IME/consultation 4/23/03 relating to 10/24/03 work injury at this time. Follow up will be scheduled following tomorrow's visit.


Gregory M. Jones, M. D.

GMJ/bjl

(429)

Neck + Back

**CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE**

**SHIVER, Gertrude
#4559**

June 4, 2003 Patient is seen in follow up, we had completed the treatment yesterday regarding left cervical facet injections. Patient is here today for the trial of Myobloc injections that we had previously discussed. Patient has had chronic myofascial pain component, this has been flared recently by work injury 10/24/02, but we had also discussed possible utilization of trigger point injections and/or chemodenervation of recalcitrant trigger points relating to MVC 4/20/97, but particularly since patient has had significant flaring of neck and shoulder girdle myofascial pain since MVA 11/25/00. Therefore, this treatment today relates not only to the significant flaring of myofascial pain component in these two regions following MVA 11/25/00, but also to the significant flaring and even worsening of any myofascial pain present since work injury and confusion to left shoulder and neck region 10/24/02.

ROS: Patient currently experiencing no significant left arm pain.

PMH: No significant change in symptoms since left sided cervical facet injections accomplished yesterday, too soon to tell what type of benefit will be achieved.

Physical Examination: Reveals significant trigger points at typical locations in this patient, and this includes left upper trapezius mid-belly, left levator scapulae, and left supraspinatus mid-belly. I have not treated any of the rhomboid, infraspinatus, or middle or lower trapezial trigger points, and no treatment accomplished on right side today, using this side as "control." Patient has significant recalcitrant/chronic trigger points at usual locations left lateral neck, including splenius capitis, splenius cervicis, posterior scalene, and anterior scalene. These are in usual locations within these muscles, but there is also significant residual tenderness left greater occipital nerve route, and still tenderness noted over cervical facets treated yesterday. No evidence of erythema or local swelling noted over sites treated yesterday. Significant trigger point also noted left sternocleidomastoid muscle at clavicular head, 2 cm above clavicle.

Impression: 1. Severe flared left sided cervicothoracic myofascial and facet-generated pain (left sided superimposed acute and underlying chronic cervical and upper shoulder girdle strain syndrome), significantly flared since most recent work-related confusion to left neck and shoulder region 10/24/02 (unresponsive to prior conservative measures, Dr. Hook), initially symptomatic S/P MVA 4/20/97 and work injury 10/11/97 (with history of severe flaring following more recent MVA 11/25/00, with development of chronic myofascial pain thereafter).
2. Known underlying/pre-existent multilevel cervical spondylosis, worse at C4-5 and C5-6 levels; rule out spondylitic (vs. discogenic) cervical pain component with left shoulder, but no current significant upper extremity complaints.
3. Chronic, but currently stable, multifactorial low back pain with discogenic (symptomatic L4-5 and L5-S1 annular tear/protrusions), multilevel facet-generated, and myofascial pain components, one or more of these components significantly flared/symptomatic S/P work-related fall from chair 3/23/02 (this flare now stable following recent series of lumbar epidural blocks), symptoms initially present in low back following work-related MVA 10/11/07; significantly flared/worsened, S/P MVA 11/25/00.

Recommendations/Discussion: In regard to patient's pathology, patient is considered at MMI as of today's date, relating to lumbar injuries and flaring of multifactorial low back pain following work-related fall from chair 3/23/02. Patient has already been assessed for impairment relating to the most severe injury of this region, specifically the MVA 11/25/00. There is no change in assumptions regarding impairments relating to this injury. Based on fact that we have no indication of a "new" injury to lumbar spine with work injury of 3/23/02, this was primarily a flaring/aggravation of underlying pre-existent multifactorial pain generators in lumbar spine.

Although there is possibility that the annular tear/contained herniation at L5-S1 or the bulge at L3-4 could be related to work injury of 3/23/02, I would suggest that no additional impairment rating is necessary relating to that injury of 3/23/02, considering fact that patient is now stable in lumbar spine, has had no significant flaring since completion of epidural blocks, and has no definite clinical evidence of worsening or true "aggravation" per *AMA Guides to the Evaluation of Permanent Impairment, 5th edition* definition, based on current understanding of patient's chronic low back pain problems.

Therefore, patient is assessed at MMI for work injuries sustained 3/23/02 to lumbar spine, and based on *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*, patient is assessed DRE Category I, 0% lumbar spine/0% whole person additional impairment relating to accident of 3/23/02 on the job. This assumption of no additional impairment is making an assumption, i.e., that patient will not require more aggressive treatment than that already necessary to maintain stability of patient's lumbar spine pathologies; those treatments being accomplished on prn basis relating to permanent impairment and injuries sustained 11/25/00. It should be noted that some of treatments post-injury 3/23/02 actually would have been necessary for ongoing care of patient relating to chronic low back pain, and this can (at least partially) be related

(430)

June 4, 2003\ page 2

Recommendations/Discussion (continued): to MVC of 11/25/00, to a reasonable degree of medical certainty.

It is noted by history that patient was involved in work-related fall in January 2003, has had significant leg and hip symptoms since that fall, and also left flank and left inguinal pain. This appears to be a separate injury from the stable low back and buttock/sciatica symptoms relating to the lumbar pathologies noted above. Patient is currently under care of separate physician for these injuries sustained on the job January 2003, and any additional or new impairments relating to this injury should be addressed by current treating physician(s) once patient at MMI. I have not addressed any additional impairments that may be related to that specific injury January 2003 on the job, to lumbar spine, as I have not been involved in the patient's care of these new injuries.

Patient is not yet considered at MMI regarding most recent injuries sustained to cervical spine, particularly in relation to work injury 10/24/02. There is no change in assessment of prior impairments or MMI relating to cervicothoracic spine injuries sustained 11/25/00 in MVC, assessed date of MMI 8/13/01. However, since patient is not yet at MMI relating to flaring/worsening of left sided neck and shoulder symptoms since work-related contusion to left neck and shoulder 10/24/02, I cannot address issues regarding MMI or any additional impairment rating (if this becomes appropriate/necessary) until patient is maximized regarding non-surgical measures available to her. It should be noted that the treatments accomplished today (see below) relate to ongoing care regarding MVC 11/25/00, as we had already discussed these options previously (Myobloc injections for recalcitrant trigger points due to chronic myofascial pain components present/flared since MVA 11/25/00) and the injury of 10/24/02 to left neck and shoulder has aggravated this portion of patient's pain in shoulder/neck region to point to where it is necessary to go ahead with the chemodenervation trial as follows:

1. Left shoulder girdle chemodenervation at supraspinatus, levator scapulae, and upper trapezius sites, three sites noted above, 500 units botulinum toxin type B (Myobloc) instilled at each site, along with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) at each site; each chemodenervation accomplished with 25 gauge 2" spinal needles, following local instillation of 1.5 cc 1% Xylocaine at each site for local anesthetic, using 27 gauge 1 1/4" needles.
2. Left lateral neck chemodenervation of scalene and splenius trigger sites, four sites noted above, 500 units botulinum toxin type B (Myobloc) instilled at each site, along with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) at each site; each chemodenervation accomplished with 25 gauge 2" spinal needles, following local instillation of 1.5 cc 1% Xylocaine at each site for local anesthetic, using 27 gauge 1 1/4" needles.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Patient is placed out of work as of yesterday through 6/5/03. Patient is to follow up in 3-5 weeks to assess response to cervical facet injections and Myobloc chemodenervation trial. I do not see any reason to consider new MRI cervical spine. If patient gets adequate relief to these two sets of injections accomplished yesterday and today, no need to consider cervical epidural. Should be able to determine best options available to patient for future medical care for flaring, based on response to these injections accomplished yesterday and today.

Gregory M. Jones, M.D.

GMI/bjl

C43L

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE

July 1, 2003\ Patient is seen in follow up. Has fortunately seen good benefit with the injections accomplished in series 6/3/03 (left cervical facet injections, 5 levels) and 6/4/03 (left shoulder girdle and left lateral neck Myobloc chemodenervation). Patient estimates overall about 80% relief. Still feels that she has persisting pain in left anterior chest wall (upper aspect) and left anterior shoulder region which is "new" and related to most recent injury on the job when a group of charts fell onto her neck and shoulder on left side.

- Impression:
1. Flared left sided cervicothoracic and shoulder girdle myofascial pain (with flared cervical facet-generated pain concomitant), secondary to work-related contusion to left neck and shoulder region 10/24/02, good relief noted with recent focal injection therapies, now considered at MMI.
 2. History of chronic multifactorial cervicalgia, worse on left, initially symptomatic following injuries 4/20/97 (MVA) and 10/11/97 (work injury) with 5% DRE Category II impairment assessed 7/29/98, followed by additional aggravation of particularly cervical facet injuries in 11/25/00 MVA, with additional 3% impairment assessed 8/13/01, date of MMI.
 3. Chronic, currently stable multifactorial low back pain.

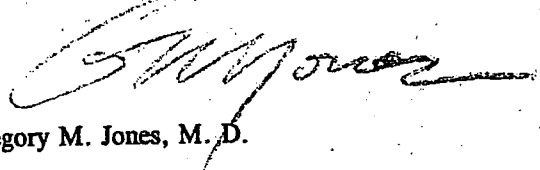
Recommendations/Discussion: There is no change regarding impairment assessed for lumbar pathology in past. Refer to 6/4/03 progress note for details.

As of today's date, we can likely assume Gertie at MMI regarding injuries sustained on the job 10/24/02 due to contusion to left neck and shoulder region with charts. Patient appears to have had flaring of primarily myofascial pain, but also had flaring of cervical facet-generated pain components on left side. Fortunately, patient has gotten significant benefit with treatment directed toward these injuries.

Assuming MMI as of today's date for work injury sustained 3/23/02 to cervical spine and left shoulder girdle, and based on *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*, I can assess no additional impairment for this injury, as previous impairments have been assessed for both myofascial and cervical facet-generated pain, which was present in this patient to great extent even prior to 10/24/02 injury on the job. Although patient does have residual anterior shoulder and left upper chest wall pain and discomfort which has appeared as "new" myofascial injury following 10/24/02 accident on the job, this would require assessment for myofascial pain, and based on recommendations per *AMA Guides to the Evaluation of Permanent Impairment, 5th edition* interpretation, it is inappropriate to add further impairments for this type of injury, particularly when impairments have addressed myofascial injuries in this region previously.

Patient had majority of injuries that have resulted in additional impairment cervical spine occurring on 11/25/00. This not only flared neck pain (particularly cervical facet-generated pain component), but also significantly flared multifactorial low back symptoms. Assessments for impairments (where necessary) have already been addressed in regard to these various injuries sustained 11/25/00.

Although patient is released today from active care regarding injuries sustained 10/24/02, patient is candidate for intermittent use of cervical facet and/or trigger point management with focal injections for flares. I can address issues regarding future medical care via Life Care Plan if this becomes necessary. Patient to continue with home exercise protocol life-long. Patient would also benefit from regular aerobic activity at least 3x weekly. Patient is allowed to continue with usual duties, as her work site requirements are primarily for sedentary work at desk/computer, where she is in health information management, working in Columbia for Palmetto Richland Memorial Hospital. There have been no additional restrictions regarding this patient relating to work injury 10/24/02. Follow up hereafter prn.


Gregory M. Jones, M. D.

GMJ/bjl

cc: Palmetto Health Trust
Attn: Lori Sharpe

(432)

FAXED
7/1/03



Human
Performance &
Rehabilitation
Centers, Inc.

Plan of Care

☒ Progress Note

☒ Discharge Summary

Patient's Name: Gertrude Shiner
DOB: 5/19/54
Chart #: 343091
Physician: Hook

Medical Diagnosis: Cervical strain
Medical Diagnosis Code: 847.0
Treatment Diagnosis: Cervical Pain
Treatment Diagnosis Code: 723.1

Goals Met: ☒ Yes ☐ No ☐ Revised
Partially

Frequency of Visits / Duration of
Episode of care: QW x 4th

Current Functional Level: Pt seen for 4 visits

Reps test / Adams test (+)

Cervical Motion WNL throughout 515 gross wt strength x:
7-8/10 pain rating
(1) Upper Trap 4/5
(2) Post Alt 4/5
(3) Latissimus Dorsi 4/5

Interventions: HEP, soft tissue Massage, PRE: Post Shld girdle, Cervical Motion

Education (Including safety, exercise and disease information): HEP, Shld / Cervical anatomy, Disc
process of muscle strain vs TOS

Who was educated? ☒ Patient/client ☐ Family (name and relationship)

How did patient/family demonstrate learning?

☒ Patient/client verbalizes understanding

☐ Family/significant other verbalizes understanding

☐ Patient/client demonstrates correctly

☒ Demonstration is unsuccessful (describe): Occasionally needs cues to correct form /
mechanics & therex

Therapist Recommendations/Plan: Recommend further follow-up & pain for possible
trigger points / TOS pt may benefit pain management clinic. It does appear
pt has TOS but also not sure how well pt is doing at home. Pt
has been given HEP to do for now and will call me if problem persists.

Therapist Signature: M. J. Y. Y. License # 3926 Date: 12/4/03

I certify the need for these services furnished under this plan of treatment and while under my care.

Physician's Signature _____ Date: _____

*Note to Physician: Please return signed white copy to HPRC by patient or mail

(433)



Human
Performance &
Rehabilitation
Centers, Inc.

PHYSICAL THERAPY INITIAL EVALUATION

Patient's Name Certude Shind

Date of Birth 5-19-54

Today's Date 11-13-02

Chart # 343091

CURRENT CONDITION(S) / CHIEF COMPLAINTS

What areas do you have problems with that brings you to our office today?

- | | |
|--|--|
| ☐ Right Leg | ☐ Left Leg |
| ☐ Right Knee | ☐ Left Knee |
| ☐ Right Ankle | ☐ Left Ankle |
| ☒ Neck Pain <u>Left side</u> | ☐ Left Shoulder |
| ☐ Right Shoulder | ☐ Left Arm |
| ☐ Right Arm | ☐ Left Elbow |
| ☐ Right Elbow | ☐ Mid Back |
| ☐ Low Back | ☐ Left Back |
| ☐ Right Back | |
| ☐ Other | |

b When did the problem(s) begin (date)? 11/02/02

c How did it happen? Injury Yes ☒ No ☐

Accident ☒ Fall ☐ Other ☐

At Work ☒ At Home ☐ Other ☐

In Competition ☐ Unknown ☐

Onset? Acute ☒ Gradual ☐

Pain Frequency? Constant ☒ Intermittent ☐

d Have you had this problem(s) before? Yes ☐ No ☒

a. What did you do for the problem(s)?

Physical Therapy ☐ Medication ☐ Physician ☒

Chiropractor ☐ Other ☐

b. Did the problem(s) get better? Yes ☒ No ☐ Still worse

c. How long did the problem(s) last? 6 weeks

e When is the problem(s) worse?

AM ☒ PM ☐ Sitting ☐ Standing ☐ Walking ☐

At night ☐ Other ☐ Constant pain

Painscale:

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10 Max. pain 7.5

f Are you seeing anyone else for the problem(s)? (Check all that apply.)

- | | |
|---|--|
| (1) ☐ Acupuncturist | (11) ☐ Orthopedist |
| (2) ☐ Cardiologist | (12) ☐ Osteopath |
| (3) ☐ Chiropractor | (13) ☐ Pediatrician |
| (4) ☐ Dentist | (14) ☐ Physical Therapist |
| (5) ☒ Family Practitioner | (15) ☐ Podiatrist |
| (6) ☐ Internist | (16) ☐ Psychologist/Counselor |
| (7) ☐ Massage Therapist | (17) ☐ Psychiatrist |
| (8) ☐ Neurologist | (18) ☐ Rheumatologist |
| (9) ☐ Obstetrician/Gynecologist | (19) ☐ Other |
| (10) ☐ Occupational Therapist | |

OTHER CLINICAL TESTS - Within the past year, have you had any of the following tests? (Check all that apply.)

- | | |
|--|---|
| a ☐ Angiogram | k ☒ MRI |
| b ☐ Biopsy | l ☐ Myelogram |
| c ☐ Bone Density | m ☐ NCV (nerve conduction velocity) |
| d ☒ Bone Scan | n ☐ Pulmonary Function Test |
| e ☒ CT Scan | o ☐ Spinal tap |
| f ☐ Doppler ultrasound | p ☐ Stress test (eg. treadmill, bicycle) |
| g ☐ Echocardiogram | q ☐ Urine tests |
| h ☐ EKG (electrocardiogram) | r ☒ X-rays |
| i ☐ EMG (electromyogram) | s ☐ Other |
| j ☒ Mammogram | |

FUNCTIONAL STATUS / ACTIVITIES LEVEL

Do you have difficulty with any of the following?
(Check all that apply.)

Locomotion / Movement:

- ☐ Walking in the house
- ☐ Walking in the community
- ☒ Walking up or down stairs
- ☐ Walking on uneven terrain
- ☐ Getting in and out of bed
- ☐ Getting in and out of a chair
- ☐ Getting in and out of a car
- ☐ Driving a car
- ☐ Riding in a car
- ☐ Sitting
- ☐ Sleeping in normal position
- ☒ Using arm for overhead activities
- ☐ Using arm for activities at shoulder level

Requires Assistive Device:

- ☒ None
- ☐ Walker
- ☐ Crutch
- ☐ Cane
- ☐ Wheelchair
- ☐ Sling

Home Management:

- ☒ Vacuuming
- ☐ Dishwashing
- ☒ Laundry
- ☐ Shopping
- ☐ Caring for Family
- ☒ Carrying groceries/bag

Personal Care:

- ☐ Grooming
- ☐ Bathing
- ☐ Dressing
- ☐ Earing
- ☐ Toileting
- ☐ Reading
- ☐ Using telephone

Community / Work Activities / Integration:

- ☐ At Work
- ☐ At School
- ☐ At Recreation/Play/Activities

What normal activities do you want to return to after completing physical therapy other than those listed above? Be able to lift objects (heavy), move them

5 lbs.

ADDITIONAL INFORMATION: I want my neck pain to return to baseline

Patient Use

(434)

Therapist Use

Medical Diagnosis Cervical StrainCodes 847.0Treatment Diagnosis Neck PainCodes 723.1Date of Onset 10/24/02Date of Start of Care 11/13/02Surgery GDate 0COMMUNICATION, AFFECT, COGNITION,
LEARNING STYLE

Communication (eg, age-appropriate)

Orientation X 3 (person/place/time)

Emotional/behavioral responses

Not
Impaired Impaired☒ ☐
☒ ☐
☒ ☐

EDUCATION NEEDS:

☐ Disease process☐ Safety☐ Use of devices/equipment☐ Activities of daily living☐ Exercise program☐ Other: _____

pt. states had chest fall onto @ side start neck or 10/24/02, been using some pt. not, and it helps some.

INTEGUMENTARY SYSTEM

Integrity

Integumentary disruption relevant to treatment area

Continuity of skin color relevant to treatment area

Not
Impaired Impaired☒ ☐
☒ ☐

MUSCULOSKELETAL SYSTEM

Not
Impaired Impaired

Gross Range of Motion

Gross Strength

Other: _____

☒ ☐
☒ ☐Other: TTP @ LT

Specific Strength:

Strength (manual muscle test): ☐ WNL ☐ Grossly impaired grading ____ / 5 except:

Muscle	Grade		Muscle	Grade	
	Left	Right		Left	Right
Shoulders	4-15	5-15		15	15
RE/BE	4-15	5-15		15	15
Triceps	4-15	5-15		15	15
Biceps	4-15	5-15		15	15
	15	15		15	15

Specific ROM:

Range of motion: ☐ Grossly impaired ☐ WNL except:

Range of motion	uninvolved R L		involved R L	
	active	passive	active	passive
Cervical				
✓ / Flex	NPL	Ext 4-32		
Rot	NPL			
SB	+ @ 152			
Shoulder	NPL	Ext 10		

☐ Additional Documentation Attached

Short Term Goals: 1) Reports to pain to 5/10 or better in 2 visits
 2) Rate 1 score less on activity scale in 3 visits
 3) 4-5 L pain by 10-152 in 3 visits

Long Term Goals: 1) Able to do 2) Arm for OH activity 3) Limitation in 4-52

Rehab Potential: Poor Fair X GoodHome Program Given X Pictures ☐ WrittenTherapeutic Exercise 10 Min. Dynamic Activity _____ Min.Tx: HEP pt. education to pos. choice of Rx

pt. has only @ LT strain & tenderness pt. should get relief @ HEP and HEP/222 @ home.

Followup: if pt. go to Orthopedic MDFrequency: @ Duration 4 wks Is patient aware of diagnosis & prognosis? ☒ Yes ☐ NoContraindications: +How does patient/client best learn? ☒ Pictures ☐ Reading ☒ Listening ☐ Demonstration ☐ Other: _____Therapist Signature / License No. 11-1111 PT 3926Date 11/13/02

(435)

Physical Therapy Progress Notes

Patient Name: Gratiana ShiverChart #: 343091

Short term goals revised until: _____

Next physician's visit: 1 / 1 / 1

DATE	11 / 1 / 2010	11 / 12 / 2010	12 / 1 / 2010	1 / 1 / 2011
SUBJECTIVE	Still feel a good bit of pain in my neck.	It's not so bad as that area. Been doing the exs though.	Still pain in my neck in the same spots. Some days I'm with my arm and a p.s.c.	
OBJECTIVE MEASUREMENTS	TTP ① SCM / Ant. Sealene, Pain 4+ Rot ①, SB ①. 8/10 R	WNL Rot ② Cerv. 1/2 - 1 score for each on Calquestone.	7-8/10 ④ Roos Test ④ Adson's Test SL5 STALL STAY R & L para. STALL 4/5 Rhomboids R4 Bulb, WTC Lateral Bow	
Therapeutic Exercise/Dynamic Activities and/or Modalities	RA. 1) Re-check status. 2) Cervical Axon x 10x. 3) Shrugs. 20x. 4) Shoulder Retractor - YTT x 15. 5) Rows. 20x YTT. Pt. cluster in Cervical Axon x 5m. Pt. isued YTT.	GA. 1) STM & Cervical/UT stretch x 10 min in Supine. P. Mand TA included. 2) Supine Sub Retrat. YTT 30x 3) Rows YTT 30x. 4) Shrugs YTT 2x10. 5) Cervical Axon 10x 6) Chin Tuck. 10x. 7) UBE x 4 min @ 100%.	RA. Rechecked for ROM RAR - STMAS on 11/26/02. Verbal review of ROP and recheck Cervical Axon.	
ASSESSMENT	UC's to correct form & thorax. Appears to have mostly seen status.	UC's for correct ex. Pt is not doing proper form nor can maintain proper form p correction.	See MD notes	
SHORT TERM GOALS	X assessed goals met Drs not meet STA #2 new goals by _____: 1. _____ 2. _____	assessed X goals met STA #2. new goals by _____: 1. _____ 2. _____	assessed X goals met for full new goals by _____: 1. _____ 2. _____	assessed _____ goals met new goals by _____: 1. _____ 2. _____
PLAN	QW Re-check.	QW, then off.	MD note with be sent, pt will call if she decides to go to MD in Charleston.	
TREATMENT TIME	Ther. Ex x 25 minutes Dyn. Act x 1 minutes	Ther. Ex x 15 minutes Dyn. Act x 4 minutes	Ther. Ex x _____ minutes Dyn. Act x _____ minutes	Ther. Ex x _____ minutes Dyn. Act x _____ minutes
CLINICIAN'S SIGNATURE	M. [Signature]	M. [Signature]	M. [Signature]	
LICENSE #	SC# 794	SC# 2926	SC# [Signature]	SC#

(436)

As:

[illegible]

with
D4
04/14/03

The ☐ Label	 SUBSTITUTION PERMITTED 2EIM0125795			
Therapies: ☐ Gait Train ☐ Isokinetic ☐ Isokinetic ☐ Orthotic ☐ Splint ☒ Home Exercise Program Functional Capacity Evaluation (F.C.E.) ☐ Impairment Rating ☐ Work Assessment and Readiness (W.A.R.)	☐ Warmup Pool ☒ Moist Heat Equipment / Supplies ☐ <i>NA</i>			
Frequency: ☐ QD ☒ QW ☐ BIW ☐ TIW Duration: <i>4</i> Weeks ☐ Months				
Goals Detailed in Therapist Evaluation <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top; padding: 5px;"> ☐ Independent Ambulation ☐ Increase strength ☒ Decrease pain ☐ Promote healing </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> ☐ Prevent post-op complications ☐ Independent exercise program ☐ Prevent joint contractures ☒ Return to full function </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> ☐ Prevent Infection ☐ Decrease edema ☐ Increase endurance ☒ Increase ROM </td> </tr> </table> Therapist signature for goals: <i>M. [Signature]</i>		☐ Independent Ambulation ☐ Increase strength ☒ Decrease pain ☐ Promote healing	☐ Prevent post-op complications ☐ Independent exercise program ☐ Prevent joint contractures ☒ Return to full function	☐ Prevent Infection ☐ Decrease edema ☐ Increase endurance ☒ Increase ROM
☐ Independent Ambulation ☐ Increase strength ☒ Decrease pain ☐ Promote healing	☐ Prevent post-op complications ☐ Independent exercise program ☐ Prevent joint contractures ☒ Return to full function	☐ Prevent Infection ☐ Decrease edema ☐ Increase endurance ☒ Increase ROM		
Vocational/rehabilitation ☒ not needed for the patient. I certify the medical necessity of services furnished under this plan of care. Physician's Signature: _____				

(437)

Therapist Use

Medical Diagnosis Cervical Strain Codes 847.0
 Treatment Diagnosis Neck Pain Codes 723.1
 Date of Onset 10/24/02 Date of Start of Care 11/13/02
 Surgery G Date 0

COMMUNICATION, AFFECT, COGNITION,
LEARNING STYLE

Communication (eg, age-appropriate)

Orientation X3 (person/place/time)

Emotional/behavioral responses

Dr. states had chart fall onto @ side start next or 10/24/02, been using some ref heat, and 17 helps some,

INTEGUMENTARY SYSTEM

Integrity

Integumentary disruption relevant to treatment area

Continuity of skin color relevant to treatment area

Other: TTP @ HTNot
Impaired ImpairedNot
Impaired Impaired

EDUCATION NEEDS:

☐ Disease process☐ Safety☐ Use of devices/equipment☐ Activities of daily living☐ Exercise program☐ Other: _____

MUSCULOSKELETAL SYSTEM

Not
Impaired Impaired

Gross Range of Motion

Gross Strength

Other: _____

Specific Strength:

Strength (manual muscle test): ☐ WNL ☐ Grossly impaired grading ___/5 except:

Specific ROM:

Range of motion: ☐ Grossly impaired ☐ WNL except:

Muscle	Grade		Muscle	Grade	
	Left	Right		Left	Right
Shrug	4-15	5-15		15	15
RE-RA	4-15	5-15		15	15
Triceps	4-15	5-15		15	15
Biceps	4-15	5-15		15	15
	15	15		15	15

Range of motion	uninvolved R L		involved R L	
	active	passive	active	passive
Cervical				
V/Flex	NPLT	SLT 4 32		
Rot	NPL			
SB	+@ASL			
Shrug	NPLT	SLT 4 32		

☐ Additional Documentation Attached

Short Term Goals: 1) Reports to pain to 5/10 or better in 2 visits
 2) Rate 1 score less on activity scale in 3 visits
 3) 4-50 L Rom by 10-1590 in 3 visits

Long Term Goals: 1) Able to @ Arm for OH activities 3 limitations in 4-5 visits

Rehab Potential: Poor Fair X Good Home Program Given X Pictures ☐ Written

Therapeutic Exercise 10 Min. Dynamic Activity 4 Min.

Tx: HEP Pt. education & POC. change of Rx

Ac. Has Bkg @ HT. Strain & tenderness Pt. should get relief @ HEP and Heat/Elec @ home.

Followup: if no @ go to @/pt/pt

Frequency: QW Duration 4 wks Is patient aware of diagnosis & prognosis? ☒ Yes ☐ No

Contraindications: +

How does patient/client best learn? ☒ Pictures ☐ Reading ☒ Listening ☐ Demonstration ☐ Other: _____

Therapist Signature / License No. 11- J. M. PT 3926

Date 11/13/02

(438)

PHYSICAL THERAPY EVAL

CHARLESTON SPINE &
PHYSICAL MEDICINE

INITIAL EVALUATION DATE: 5/13/03

NAME: Gertrude Shiver

REFERRING MD: Dr. Greg Jones

DIAGNOSIS: _____

AGE: 48 CHART # 4559

PMHx: ⓐ Achilles tendon + heel
problem. back pain,
flat feet.

PSHx: Occ: Medical Records.
at Richland Memorial.
Activities: Gym activities.
to reduce weight.

PREGNANT? Y/N

MEDS: Hydrocodone, Percocet,
Ultram.

TESTS: MRI, X-rays

CHIEF COMPLAINT: ⓐ sided neck pain

HISTORY (aggravating factors, current state): Pt is MVA in year 2002 injuring
neck. Pt then reports 40-worker dropped what ^{was} ~~she~~ ^{her} ~~she~~
neck October 24, 2002. Pt reports constant neck pain.
Pt denies any radiating symptoms to arms.
Pt also reports buttocks pain and ⓐ heel pain
which Dr. Jones did not address.

PAIN SCALE: 1/10 7-8/10 7-8/10 right now.

ALLEVIATING FACTORS: hot meds.

FUNCTIONAL LIMITATIONS: unable to perform certain activities such
as lifting heavy objects because of neck pain.

OBSERVATIONS: overweight female ⓐ sided C-spine
head aches from facet injections lately.

(439)

PHYSICAL THERAPY EVAL

AROM: 90% C-spine flex 50% Ext, 70% @ rotation,
60% @ side bending
@ shoulder ROM WNL

STRENGTH: 4/5 strength to @ UE for shoulder
flex, Abd, biceps, Triceps.

REFLEXES/SENSATION: 2+ reflexes @ UE
sensation intact @ to light touch.

PALPATION: rt tender to @ upper trap and
levator scapulae

SPECIAL TESTS: @ Spurling restricted lower cervical
spine and upper thoracic spine 2 segmental
mobility testing.

GAIT: Not tested.

ASSESSMENT: 48 y/o female complaining of @ sided neck pain
3 radiating symptoms.

LT GOALS & TIME FRAME:

^{thoracic}
ST GOALS & TIME FRAME: ① To V muscle spasm to C-spine & T-spine

② Rt & L pain to @ C-spine

TREATMENT TODAY: EVAL PLUS moist heat and E-stim to C-spine paraspinal.

RESPONSE: Pt felt V muscle spasm to C-spine following tx.

TREATMENT PLAN: Pt to receive modalities following injection procedures

THERAPIST: Paul Becher MPT LIC. # 4585

CHARGES: 97001, 97014, 97010

(440)



PATIENT NAME

Gortade Silver

PATIENT #

4669

MALE

FEMALE



DATE

PROGRESS NOTES

1/3/03 S: Pt reports she feels injections are helping neck condition.
 O: Pt 2 injection sites along @ C-spine today. Rx:
 Moist heat @ C-spine to G-spine & T-spine paraspinals
 A: Pt tol K-stim well today and noted a discomfort.
 P: Planta cont a reduction post injections.
 charges: 97014 x2, 97010
 P. J. Healy MSPT.

1/4/03 S: Pt reports injections cont to help neck condition.
 O: Pt 2 injection sites along @ upper back today. Rx:
 Moist heat to upper thoracic paraspinals
 A: Pt tol all modalities well today.
 P: Planta cont to progress toward increased function.
 charges: 97014 x2, 97010
 P. J. Healy MSPT.

RETURN TO WORK OR SCHOOL

Gregory M. Jones, M.D.
Timothy M. Zgleszewski, M.D.
Charleston Spine and Physical Medicine, P.A.

1930 Charlie Hall Blvd., Charleston, SC 29414
Satellite Office in Georgetown
(843) 402-0111 • 1-800-393-7008 • Fax: (843) 402-9010

This is to certify that

Date

7/1/03

Bartolome Shiver
has been under my care for the following:

chronic cervical pain, S1P contusion

② shoulder/neck 10/24/02 →
stable

and is able to return to

work

school

on

7/1/03

Remarks:

no additional restrictions
necessary from standpoint of
work injury 10/24/02
to cervical / shoulder / neck
regions

(SIGNATURE)

(SIGNATURE)

(SIGNATURE)

(SIGNATURE)

(442)

RETURN TO WORK OR SCHOOL

Gregory M. Jones, M.D.
Charleston Spine and Physical Medicine, P.A.

1930 Charlie Hall Blvd., Charleston, SC 29414
(843) 402-0111 • 1-800-393-7008 • Fax: (843) 402-9010

Date 6-3-03

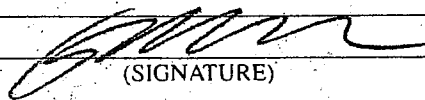
This is to certify that

Gertrude Shiver
has been under my care for the following:

(L) neck pain, (L)
shoulder pain

and is able to return to work on 6-5-03
school

Remarks: off today & tomorrow
post cervical & facs injections
(today) and post (L) lateral
neck &/or upper shoulder
trigger point chemotherapy
with botax type B (hyalco.)


(SIGNATURE)

(SIGNATURE)

(SIGNATURE)

(SIGNATURE)

(443)

TAYLOR AT MARION ST.
COLUMBIA, SC 29220

EMERGENCY DEPARTMENT RECORD

DISPOSITION

TIME:

PATIENT ACCOUNT NUMBER

0302400465

FORM PRINT DATE & TIME

01/24/03 17:49

REG. BY

MEG

DATE OF SERVICE

01/24/03

REG TYPE

ERB

SV CODE

EMS

COUR DIS

72

TIME OF ARRIVAL

17:49pm

MEDICAL RECORD NO.

000521249

NAME AND ADDRESS

SHIVER, GERTRUDE

1026 CONGAREE CHURCH ROA

SOCIAL SECURITY NUMBER

249-98-2546

GUARANTOR

SHIVER, GERTRUDE

1026 CONGAREE CHURCH ROAD

SOCIAL SECURITY NUMBER

249-98-2546

REL

Q

GADSDEN SC 29052

PHONE

(803)353-3892

GADSDEN SC 29052

PHONE

(803)353-3892

SEX

F

RACE

81

MS

S

DATE OF BIRTH

05/19/54

AGE

48Y

EMPLOYER

RICHLAND MEM.HOSPITA

OCCUPATION

BCBS PPC/PREFERRED BLUE

I-20 AT ALPINE ROAD

COLUMBIA SC PALMETTO

ZCW249982546 SS#:249-98-2546

LIVING WILL

NO

1500 BCBS PPC

PO BOX 100300

COLUMBIA SC 29202

ZCW249982546 PALMETTO RICHLAND

3rd INS.

CHIEF COMPLAINT

PT STS NAUSEA/DRY HEAVES/BODY PAI

PHYSICIAN

EMS,EMS

ACCIDENT ACCIDENT DATE AND TIME

REFERRING PHYSICIAN

EMS,EMS

COMMENT

ARRIVED BY:

ACCOMPANIED BY:

LAST T.T.

CURRENT MEDICATIONS

SEL

PATIENT HISTORY

TIME

TEMP.

PULSE

RESP.

B/P

ALLERGIES

NOTIFIED

AT

RESP.

Hx + Px

(TIME:

☐ Dictated

NURSE

PATIENT ORDERS

DIAGNOSIS

PHYSICIAN'S SIGNATURE

DATE

CONDITION

☐ IMPROVED☐ OTHER

AT DISCHARGE

☐ TX-STABLE☐ SATISFACTORY

D/C VIA

☐ AMBULATORY☐ CRUTCHES☐ WHEELCHAIR

DISCHARGE DATE

DISCHARGE TIME

FINAL DISPOSITION OF PATIENT:

☐ TREATED☐ ADMITTED TO:☐ TRANSFERRED

AND RELEASED

(444)

PALMETTO HEALTH BAPTIST

EMERGENCY DEPARTMENT

Triage Class
Emergent Urgent Nonurgent

Name: Shiver, Bertrude Age: 48 Weight: _____

Date: 01/24/03 Accompanied by: Self Tetanus: _____

VT MD: J. Hooks LMP: 2 wks ago Immun: _____

Mode of Arrival: ☐ EMS ☐ WC ☐ Amb ☐ Carried Seen in ER past 30 days: ☒

ALLERGIES: Sulfas drugs, PPD test, IVP dye

Y N
☐ ☒ Previous Hx of latex allergy
☐ ☒ History of spina bifida
3. ☐ ☒ Prior latex reaction of hives and / or airway swelling
4. ☒ ? Allergic reaction during prior surgery or Bar. Enema
10P dye

CHIEF COMPLAINT	ER Rm # <u>2V</u>	Meds
<u>10 nausea, dry heaves, @ side abd</u>		<u>Darvocet</u>
<u>pain, perineal pain, @ foot, @ knee, @ mobic</u>		<u>Steloxin</u>
<u>back of neck pain, lower back pain</u>		<u>Tenaxin</u>
<u>Elbow pain. Status fell early</u>		<u>Cardion</u>
<u>Just am (1230a) as she was</u>		
<u>leaving work onto wet floor.</u>		
Triage Nurse: <u>DeLury/Rupple</u>	Primary Nurses: 1. _____	
	2. _____	

Triage Vitals: T: 97.3 @ P: 109 R: 18 BP: 110/85 02 Sat: 100% O

Trauma Alert Yes _____ No _____

standing 0220/ 109 * 11/78 PHYSICIAN ASSESSMENT * Dictated ☐

Hx: 48 F C/O pain in (L) chest, lower abd,
between thighs, (L) knee/ankle.
Fell on '12' as she was leaving
work. Fell onto wet floor.

PMH: Chronic neck + muscle FH: _____ ROS: _____
pain
arrhythmia

SH: _____

PE: Abd. NAD: CXR C
ambulatory. (L) ankle C
Lungs - clear, BS = C/A 1.028
Cor - neg 1-3R
abd - soft, mildly 6-20 W
tender (L) abd. few brkts. few gtr
Tach @ chest / feet @ visible tons
(L) ankle @ swelling.
knee - NT @ swelling R/OA.

Diagnosis

1. <u>multiple musculoskeletal</u>	Condition on D/C ☐ Improved ☐ Guarded ☐ Tx Stable ☐ Critical	Physician's Signature <u>K. Mobley</u>
2. <u>contusions / strains</u> <u>S/L foot</u>		

(445)

Severe to moderate

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

with history of dis-
comfort

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, reflux with overlapping stricture status post dilation and chronic back and neck pain, who basically presents with severe left-sided rib and abdominal discomfort status post fall. The patient notes that on 01/21/03, she actually slipped on a wet floor at work, landing on her left side and rib cage. She had a tremendous amount of discomfort almost immediately. She claims that not only was she having a significant amount of left-sided rib and abdominal discomfort but it also exacerbated her underlying neck and back pain as well. Apparently, the patient was seen by a nursing supervisor who suspected that the patient was seeking narcotics and actually the patient had a breathalyzer test as well. This apparently returned normal. Nonetheless, the patient felt that due to the fact that she had not seen a physician, went to Baptist ER. At that time, she had some rib films which were negative. Due to the fact that she was having abdominal discomfort and actually some suprapubic discomfort as well, a urinalysis was run and she was found to have a urinary tract infection. She was placed on Macrochantin. The patient noted that briefly this seemed to help with some of her discomfort but it has since returned. Again, she claims that associated with this discomfort, she has had some nausea and at one point some vomiting. She has also had some mild loose stool. She denies any fever or chills. She continues to have suprapubic discomfort as well as some peroneal irritation as well. She has been somewhat hesitant to take any Darvocet for the pain due to the fact that she is concerned that a urine drug screen may show narcotics and thus has basically been trying to take care of this pain with heating pads and ice as well as rest. She also notes that she is having some discomfort in her left foot, left knee, left elbow, and left shoulder on the side in which she fell. The patient claims she is quite concerned that no one is taking her complaints seriously. She notes that she feels that there is some internal damage done and this has not been addressed by any of the physicians she has seen thus far. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.
ALLERGIES: Unchanged as previously documented in the chart.
MEDICATIONS: Unchanged as previously documented in the chart.
SOCIAL HISTORY: Unchanged as previously documented in the chart.
FAMILY HISTORY: Unchanged as previously documented in the chart.

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

PAGE 2 of 3

REVIEW OF MEDICATIONS:

1. Tenormin 25mg bid
2. Cardizem CD 120mg q day
3. Mobic 7.5mg bid
4. Baby aspirin daily
5. Occasional Tylenol
6. Skelaxin and Flexeril prn
7. Occasional Green Tea.

REVIEW OF SYSTEMS: The patient notes that she had to re-institute her Cardizem due to the fact that she was having some mild breakthrough palpitations. She notes that she is having no urinary symptoms at this time and claims that for the most part, her bowels have somewhat regulated, even though they are relatively loose but continues to have some formed products. She denies any rectal bleeding, or dark or tarry stool. The patient denies any abdominal distention but notes, again, severe left-sided discomfort as well as continued suprapubic discomfort. The patient also notes that she is having clear phlegm in her throat that is sometimes hard to clear. She feels that this is likely coming from post nasal drip but wants to have an ENT referral. She really has no other major complaints. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Moderately anxious. In no acute distress.

HEENT: Unremarkable.

NECK: Some left-sided muscular tension, otherwise unremarkable.

LUNGS: Clear.

CARDIOVASCULAR: Regular.

CHEST WALL: There is moderate distal left-sided rib tenderness in the lateral aspect.

ABDOMEN: Obese, soft, moderate diffuse tenderness in the left upper and left lower quadrants, radiating to the suprapubic area. There is no rebound or guarding. There is no hepatosplenomegaly or mass.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

LABS: Urinalysis was run and negative.

(447)

MIDLANDS INTERNAL MEDICINE

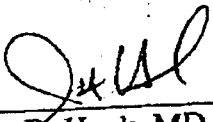
OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

PAGE 3 of 3

ASSESSMENT AND PLAN:

1. Diffuse generalized abdominal pain, most notably left-sided and suprapubic status post fall. Again, I have reassured the patient that I feel that this is likely more musculoskeletal due to her recent fall with bruised ribs and likely an abdominal strain. However, she feels that there is more going on. We will go ahead and obtain abdominal and pelvic CT with and without contrast for further evaluation. In the meantime, we will place the patient on Ultram, which should not turn her drug screen positive, if this is some concern of her place of work. She should continue, obviously, with the Mobic and use the muscle relaxers as needed.
2. Paroxysmal supraventricular tachycardia. Stable once adding her Cardizem back to her regimen. We will continue.
3. Cervical/trapezius strain. Again, the patient has seen The Spine Clinic in Charleston. They basically have recommended physical therapy.
4. Reflux. Stable on Aciphex.
5. Post nasal drip. We will try the patient on Clarinex. We have given her some samples. If she does not see any improvement there, consider nasal inhaled steroids. I do not feel that ENT referral at this time is necessary.
6. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

(448)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for complete physical exam. The patient notes that she is continuing to have a moderate amount of neck discomfort, which somewhat radiates into her left shoulder. This all occurred after a chart from the hospital dropped on her shoulder region. She has undergone physical therapy with very little in the way of improvement. She otherwise has no major complaints.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995

ALLERGIES:

1. Tetanus caused severe edema and induration with pain
2. CT dye gave her hives and palpitations.
3. PPD caused hives and palpitations as well.

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Mobic 7.5mg bid *8x7h*
4. Baby aspirin daily
5. Occasional Tylenol.
6. Skelaxin and Flexeril prn
7. Aciphex 20mg q day
8. Humibid LA bid

SOCIAL HISTORY: The patient does not smoke, nor does she use alcohol. She is not married and has no children. She is not sexually active. She is originally from Gaston and lived in Charleston but has been in Columbia since 1998. She was a cardiac nurse but became disabled due to back pain. She now works in Medical Records for Richland Memorial Hospital and does note a moderate amount of stress.

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MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03

PAGE 2 of 3

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90. She had diabetes, dementia, and actually had a stroke in the end as well. She denies any significant heart disease in the family but does note hypertension and strokes. She also notes diabetes as well as breast cancer. She had a sister in her 50's that was recently diagnosed with colon cancer. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is poor. Her exercise is minimal.

REVIEW OF SYSTEMS: The patient continues to get occasional headaches. These, if anything have somewhat improved. She has her eyes checked regularly. She does note occasional mild dysphagia but this has improved with Aciphex and is not to the point where she needs repeat dilation. She notes occasional nauseated episodes but cannot give any further details in this regards. She denies any significant palpitations as of recent and has done well on her current regimen. She notes, again, diffuse pain in her neck and shoulder region as well as her lower back. She also continues to have some problems with abdominal discomfort but has had normal CT scan of the abdomen and pelvis as of recent. She notes a lesion on her left big toe that she would like to have removed. She really has no other major complaints, other than that of moderate fatigue. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round and reactive to light and accommodation. Extra-ocular movements intact. Funduscopic exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No lymphadenopathy. No thyromegaly. No bruits.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. There are no murmurs, rubs, or gallops.

ABDOMEN: Soft, nontender, nondistended. There are positive bowel sounds in all quadrants. There is no hepatosplenomegaly or mass.

BREASTS: No palpable masses. Mild fibrocystic changes. No nipple inversion. No skin dimpling.

(450)

**MIDLANDS INTERNAL MEDICINE
PHYSICAL EXAMINATION**

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03
PAGE 3 of 3

PHYSICAL EXAMINATION: (cont.)

UROGENITAL: The patient has normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable.

RECTAL: No masses. Normal sphincter tone. Guaiac negative stool.

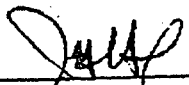
EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS: EKG was obtained and reveals a sinus bradycardia and nonspecific STT wave abnormalities, otherwise unchanged from prior tracings.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Extremely well controlled with current regimen, on Cardizem CD and Tenormin. Will continue with this regimen.
2. Reflux with overlapping stricture, status post dilation. Has improved with Aciphex. Will continue.
3. Adenomatous polyp. The patient had colonoscopy performed in May, 2002, which revealed a tubular adenoma. She will have repeat colonoscopy in two years.
4. Hoarseness. Had been a complaint. The patient went to see ENT, who basically claimed the patient had muscle tension dysphonia. She did have fiber optic exam, which basically was unremarkable. The patient was given speech therapy and Humibid LA. She claims that she was not completely satisfied with her evaluation.
5. Neck pain. Will send back to Charleston Spine Institute, which the patient has been followed there closely.
6. Chronic back pain. Again, followed by the Spine Institute. We will switch her Mobic over to Bextra, which hopefully will give her more relief.
7. Abdominal discomfort. The patient continues to have mild tenderness in the left upper and left lower quadrant, radiating to the suprapubic area. Again, there are no significant findings here. We will continue to follow. The patient was reassured in regards to a normal CT scan.
8. Lesion, left big toe. It appears that the patient has a small cyst on her left great toe tendon sheath. She was reassured.
9. Routine health maintenance. Have gotten the patient completely up to date. We will continue to follow closely.



Jeffrey D. Hook, MD

(451)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/11/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for follow-up of her multiple medical problems. Since last being seen, the patient has gone to the Charleston Spine Institute and apparently has had questionable nerve block but definitely an epidural steroid injection in the neck region. She notes that this has been somewhat helpful for her. She also feels as though the Bextra has been better tolerated and has given her more relief. The patient also notes that she apparently had some Botox injections in the neck as well. She now notes that she is continuing to have problems with her left ankle. This has been somewhat long-standing and she has seen Neurology as well as Orthopedics for this. She is requesting a second opinion and has basically been set up with Dr. McBride at the University Clinics. Apparently, this ankle and foot has given her a tremendous amount of pain status post trauma and we have discussed the possibility of this perhaps being a reflex sympathetic dystrophy, even though I have told her that an orthopedist or a neurologist would need to make this absolute diagnosis. She really has no other major complaints and otherwise feels relatively well. She denies that she has had any palpitations and notes that her blood pressure has been well controlled. She has very little in the way of complaints at this time.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.
ALLERGIES: Unchanged since previously documented in the chart.
MEDICATIONS: Unchanged since previously documented in the chart.
SOCIAL HISTORY: Unchanged since previously documented in the chart.
FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin and Flexeril prn
7. Aciphex 20mg q day
8. Ultram prn

(452)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/11/03

PAGE 2 of 2

REVIEW OF SYSTEMS: The patient notes that the hoarseness that she had evaluated by ENT has completely resolved. She was taking Humibid LA short term. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac but regular.

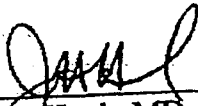
ABDOMEN: Benign.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Well controlled with current regimen. Will continue with this as the patient is asymptomatic.
2. Reflux with overlapping stricture. Asymptomatic with Aciphex. Will continue.
3. Adenomatous polyp. The patient will have repeat colonoscopy in May of 2004.
4. Hoarseness. Completely resolved. She did use Humibid LA as needed.
5. Neck pain. Has improved with Botox injections as well as an epidural steroid injection, perhaps even a nerve block. Will follow at the Charleston Spine Institute.
6. Back pain. Again, followed by the Charleston Spine Institute. Continue Bextra and Ultram as needed.
7. Left ankle pain. Again, have encouraged her to obtain further work-up. Consider the diagnosis of reflex sympathetic dystrophy and she may actually see some improvement with Neurontin. We will hold off on this until further diagnosis is made.
8. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

(453)

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 09/03/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for worsening back pain status post fall on 08/13/03. The patient apparently "slipped" on carpet at a conference and landed quite violently on her buttocks. She claims that since that time, she has had a moderate amount of low back pain. She claims that she has recently begun to feel a "pop" in her back with torsion of the trunk and at times will feel a radiating pain down into her left lower extremity. She has had disc problems in the past and has been evaluated by The Spine Clinic in Charleston. She has had numerous falls and various traumas in the past and seems to be somewhat inclined to get injured relatively easily. She has gone through numerous Workman's Comp cases and again has a very low threshold for pain. She denies any change in her bowel or bladder and denies any lower extremity weakness or numbness. She has gone to The Brace and Boot Shop and she has had a back brace made for her, which she claims has helped. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.
ALLERGIES: Unchanged since previously documented in the chart.
MEDICATIONS: Unchanged since previously documented in the chart.
SOCIAL HISTORY: Unchanged since previously documented in the chart.
FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. Aciphex 20mg q day

REVIEW OF SYSTEMS: See History of Present Illness. The patient denies any palpitations, etc. All other systems reviewed at this time and negative.

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 09/03/03

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress, mildly anxious.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac and regular.

ABDOMEN: Benign.

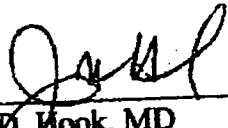
BACK: No significant spinous process tenderness. Straight leg raise is positive on the left.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Back pain status post fall. At this time, we will treat the patient with a Medrol dose pack. She may have a small herniated disc. If she sees no improvement, will obtain lumbosacral spine films, even though she has had numerous films performed in the past and has actually had an MRI of the lumbosacral spine within the year. We will follow closely. The patient was also given a few Lortab to take in place of her Ultram if absolutely needed. She was given Lortab 5mg, 50 with no refills. She can continue with Skelaxin and was encouraged to continue her back strengthening exercises.
2. Reflux with overlapping stricture. Asymptomatic with Aciphex.
3. Paroxysmal supraventricular tachycardia. Well controlled with current regimen. Will follow.
4. Left ankle pain. Will be seeing Dr. McBride. Again, it is felt that she may have a reflex sympathetic dystrophy.
5. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

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June 4, 2003\ page 2

Recommendations/Discussion (continued): to MVC of 11/25/00, to a reasonable degree of medical certainty.

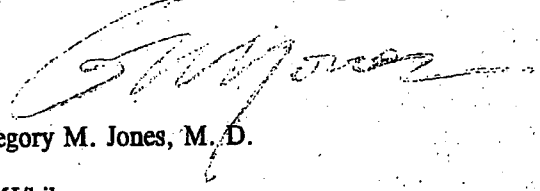
It is noted by history that patient was involved in work-related fall in January 2003, has had significant leg and hip symptoms since that fall, and also left flank and left inguinal pain. This appears to be a separate injury from the stable low back and buttock/sciatica symptoms relating to the lumbar pathologies noted above. Patient is currently under care of separate physician for these injuries sustained on the job January 2003, and any additional or new impairments relating to this injury should be addressed by current treating physician(s), once patient at MMI. I have not addressed any additional impairments that may be related to that specific injury January 2003 on the job, to lumbar spine, as I have not been involved in the patient's care of these new injuries.

Patient is not yet considered at MMI regarding most recent injuries sustained to cervical spine, particularly in relation to work injury 10/24/02. There is no change in assessment of prior impairments or MMI relating to cervicothoracic spine injuries sustained 11/25/00 in MVC, assessed date of MMI 8/13/01. However, since patient is not yet at MMI relating to flaring/worsening of left sided neck and shoulder symptoms since work-related contusion to left neck and shoulder 10/24/02, I cannot address issues regarding MMI or any additional impairment rating (if this becomes appropriate/necessary) until patient is maximized regarding non-surgical measures available to her. It should be noted that the treatments accomplished today (see below) relate to ongoing care regarding MVC 11/25/00, as we had already discussed these options previously (Myobloc injections for recalcitrant trigger points due to chronic myofascial pain components present/flared since MVA 11/25/00) and the injury of 10/24/02 to left neck and shoulder has aggravated this portion of patient's pain in shoulder/neck region to point to where it is necessary to go ahead with the chemodenervation trial as follows:

1. Left shoulder girdle chemodenervation at supraspinatus, levator scapulae, and upper trapezius sites, three sites noted above, 500 units botulinum toxin type B (Myobloc) instilled at each site, along with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) at each site; each chemodenervation accomplished with 25 gauge 2" spinal needles, following local instillation of 1.5 cc 1% Xylocaine at each site for local anesthetic, using 27 gauge 1 1/4" needles.
2. Left lateral neck chemodenervation of scalene and splenius trigger sites, four sites noted above, 500 units botulinum toxin type B (Myobloc) instilled at each site, along with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) at each site; each chemodenervation accomplished with 25 gauge 2" spinal needles, following local instillation of 1.5 cc 1% Xylocaine at each site for local anesthetic, using 27 gauge 1 1/4" needles.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Patient is placed out of work as of yesterday through 6/5/03. Patient is to follow up in 3-5 weeks to assess response to cervical facet injections and Myobloc chemodenervation trial. I do not see any reason to consider new MRI cervical spine. If patient gets adequate relief to these two sets of injections accomplished yesterday and today, no need to consider cervical epidural. Should be able to determine best options available to patient for future medical care for flaring, based on response to these injections accomplished yesterday and today.


Gregory M. Jones, M.D.

GMJ/bjl

(456)



Carolina Medical Imaging

A new image for the Carolinas

PATIENT: Gertrude Shiver
DATE OF BIRTH: 5/19/54
REF PHYSICIAN: Dr. Hook
DATE OF EXAM: 02/26/03
PATIENT PH#: 803-353-9714

CT OF THE ABDOMEN

HISTORY: Abdominal pain, nausea, and vomiting.

TECHNIQUE: CT scan of the abdomen was performed without I.V. contrast material and with oral contrast material.

FINDINGS: CT scan of the abdomen demonstrates that the hepatic parenchyma appears unremarkable. The spleen appears normal. The kidneys and adrenals appear to be unremarkable. The pancreas appears to be normal. The bowel gas pattern is non-diagnostic.

IMPRESSION:

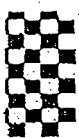
1. Normal CT scan of the abdomen with oral contrast material. I.V. contrast material was not administered.

h 2
G. Paul Forsyth, MD
Radiologist

GPF/dag

(457)

13



Carolina Medical Imaging

A new image for the Carolinas

PATIENT: Gertrude Shiver
DATE OF BIRTH: 05/19/54
REF PHYSICIAN: Dr. Hook
DATE OF EXAM: 02/26/03
PATIENT PH#: 803-353-9714

CT OF THE PELVIS

HISTORY: Abdominal pain, nausea, and vomiting.

TECHNIQUE: Pelvic CT Images were performed with oral contrast material. I.V. contrast material was not administered.

FINDINGS: The pelvic structures and adnexal regions appear to be clear. The uterus and bladder appear unremarkable. The Inguinal regions appear unremarkable.

IMPRESSION:

1. Normal pelvic CT scan with oral contrast material. I.V. contrast material was not administered.


G. Paul Forsyth, MD
Radiologist

GPF/dag

woffy
CT pelvis / 26d
completely
normal
P.H.
02/27/03

Normal
fb

(458)

110
10

HEALTHWORKS
SALIVA/BREATH ALCOHOL TESTING FORM (Non-DOT)

Step 1: To be completed by technician

A. Employee name Gertrude Enright
B. Social security number 219-98-2516
C. Employer name, Salmon Creek School District
Address, & 5000 1st St
Telephone no. 509-223-2003
D. Reason for test: Pre-placement, Random, ☒ Reasonable suspicion, Post-accident,
Return to duty, Follow-up, Other

Step 2: To be completed by employee

The identifying information provided on this form is true and correct. I understand that if the results are 0.02 or greater, I must submit to a breath alcohol confirmation test.

Debra Thorne 01/21/03
Signature of employee Date

Step 3: To be completed by technician

Screening test: Complete only if the testing device is not designed to print the following:

Test number	Testing device name	Lot number	Time	Results
<u>1098</u>	<u>Intox 2010</u>			

Confirmation test: Affix results to the back of each copy of this form.

Remarks: _____

Gertrude Enright Debra Thorne 01/21/03
Technician's name (print) Technician's signature Date

Step 4: To be completed by employee

I certify that I have submitted to the saliva and/or breath alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive or perform safety sensitive duties if the results are 0.02 or greater.

Gertrude Enright 01/21/03
Signature of employee Date

(459)

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE LAB ACCESSION NO. _____

A. Employer Name, Address, I.D. No. _____

B. MRO Name, Address, Phone and Fax No. _____

C. Donor I.D. No. _____

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Return to Duty ☐ Follow-up

Donor Name (First, Last) _____

☐ Reasonable Suspicion/Cause ☐ Post Accident

☐ Other (specify) _____

E. Drug Tests to be Performed: _____

F. Collection Site Address: _____

Collector Phone No. _____

Collector Fax No. _____

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☐ Yes ☐ No, enter remark _____

Specimen Collection ☐ Split ☐ Single ☐ None Provided (Enter Remark) _____

☐ Observed (Enter Remark) _____

REMARKS: _____

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted.

SPECIMEN BOTTLE(S) RELEASED TO:

Signature of Collector _____

(PRINT) Collector's Name (First, MI, Last) _____

Time and Date of Collection _____

Mo. Day Year

AM PM

Name of Delivery Service Transferring Specimen to Lab _____

RECEIVED AT LAB

Signature of Accessioner _____

(PRINT) Accessioner's Name (First, MI, Last) _____

Date (Mo./Day/Yr.) _____

Primary Specimen Bottle Seal Intact

☐ Yes ☐ No, enter remarks below _____

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5: COMPLETED BY DONOR

I hereby consent to have a specimen of my urine and/or blood taken, and I understand that it will be used for drug analysis by Clinical Reference Laboratory, with the results of the tests on my specimen being made available to the above named Company/Employer. I hereby release Clinical Reference Laboratory and their employees, agents and representatives from any and all liability arising from the release of the information discovered from my test. I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; that each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.

First _____ MI _____

Last _____

(PRINT) Donor's Name (First, MI, Last) _____

Collection Date _____

Signature of Donor _____

Daytime Phone No. (____) _____

Evening Phone No. (____) _____

Date of Birth _____

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

My determination/verification is:

☐ Negative ☐ Positive ☐ Test Cancelled ☐ Refusal To Test because:

☐ Dilute ☐ Adulterated ☐ Substituted

REMARKS _____

Signature of Medical Review Officer _____

(PRINT) Medical Review Officer's Name (First, MI, Last) _____

Date (Mo./Day/Yr.) _____

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

My determination/verification for the split specimen (if tested) is:

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON _____

Signature of Medical Review Officer _____

(PRINT) Medical Review Officer's Name (First, MI, Last) _____

Date (Mo./Day/Yr.) _____

(460)

Radiology Services
Baptist Medical Center
Columbia, SC 29220

Patient Name SHIVER, GERTRUDE Address 1026 CONGAREE CHURCH ROAD 249-98-2546 SS# MR#
City SADSSEN - 24 ST Zip Code 29052 CPT: 71020 Account# B0302400465
Check in D/T 01/25/03 0333 DOB 05/19/54 Age 48Y Sex F Room# DIS - ERB Pat Type ERB Release D/T 01/25/03 1502
Ordering Physician MOBLEY, KAREN C Admitting Physician EMS, EMS
PBMCC EMERGENCY DEPT.
TAYLOR @ MARION STREET
COLUMBIA SC 29220 Ordering Phy# 40948

Chk-in Date 01/25/03 Chk-in # 3544854 Exam 02001 CR CHEST PA & LAT
Ord Diag: 719.47-JOINT PAIN-ANKLE

Frontal and lateral views of the chest were obtained. The heart is normal in size. The lungs are clear. Costophrenic angles are sharp. Bony structures appear intact.

IMPRESSION: No acute pulmonary disease detected.

Read By/WILLIAM JOHN SAVOCA, M.D. 14465
/Released By/ WILLIAM JOHN SAVOCA, M.D.

01/25/03 1502
MLF

OK
JH

FINAL

(461)

UNIT RECORD	DATE	TIME	BIRTH DATE	AGE	MOTHER'S MAIDEN NAME	SEX	MAR	RACE	PRE REG #	PATIENT NO.
009952117	10/24/03	00:49	05/19/54	49Y	LUCY	F	S	B		ERR0329700191
NAME, ADDRESS			MIDDLE NAME, PHONE, SOC. SEC.		FINANCIAL DATA		ADM. BY		ACCIDENT DATE AND TIME	
SHIVER, GERTRUDE 1026 CONGAREE CHURCH ROA			(803)353-3892 249-98-2546		PALMETTO RICHLAND WORKERS		JMM		10/23/03 20:00	
GADSDEN SC 29052			PHONE		REGULAR PHYSICIAN		REQUESTED PHYSICIAN		EMS, EMS	
RESPONSIBLE PARTY			PHONE		MODE OF ARRIVAL		SELF DRIVEN			
SHIVER, GERTRUDE 1026 CONGAREE CHURCH ROAD			249-98-2546 Q (803)353-3892		VALUABLES: ☐ YES ☐ NO WHERE?					
GADSDEN SC 29052					BELONGINGS: ☐ HOME ☐ WITH PATIENT ☐ OTHER					
CHIEF COMPLAINT FALL					DATE OF LAST VISIT: 09/08/03		LAST TETANUS:		TIME TO TREATMENT: 0140	
VITAL SIGNS	TEMP. 98	☐ ORAL ☐ RECTAL PULSE 70	RESP. 20	BLOOD PRESS. 111/74	PULSE OX	LMP:	NURSE'S SIGNATURE			
VITAL SIGNS	TEMP.	☐ ORAL ☐ RECTAL PULSE	RESP.	BLOOD PRESS.	PULSE OX	WEIGHT:	TIME OUT: 0350			
HISTORY: Patient reports tripping on a phone cord and fell on both knees and caught herself on her wrist/hands & now w/ (B) knee pain & low back pain & left body pain.						ALLERGIES: only TD. CT contrast		TIME		LABS AND X-RAY
ROS: Sn / v / D / C / HA / chills						REST OF ROS: neg				
FH: DM, CVA						SH: Tobacco, SECTH, work in medical records @ PRM+				
PMH / MEDS: HTN, GERD, herniated disk / tenosynovitis, cardizem, acetex, ultrox, verfra, xanax										
PHYSICAL: General - Alert, NT, pleasant HEENT - nl / AT, mm, og dem neck - supple lungs - CTA @ cv - heppin 5 mile Abd - soft, NT, no RBS skin - warm, dry, intact muscle - 5/10 IE, minimal hp @ wrist; no swelling box hp										
CLINICAL IMPRESSION: (1) Acute minor knee, wrist, chest wall contusions										
TREATMENT: 600mg motrin / 5mg Valium p.o.										
DISPOSITION/SPECIAL PATIENT INSTRUCTIONS (1) d/c to home (2) motrin for pain (3) follow up for wound (4) follow up for wrist in 1 week										
PRESENT AND REVIEWED WITH RESIDENT										
CONDITION OF DISCHARGE		ADMIT ROOM:		TIME SEEN BY MD: 1504h		MEETS DISCHARGE CRITERIA: ☐ YES ☐ NO				
☐ SAME ☐ IMPROVED ☐ OTHER										

(462)

PALMETTO HEALTH



Emergency Department
Triage Note

Patient Name: SHIVER, GERTRUDE
MRN: 9952117
DOB: 05/19/1954 Age: 49 Years
Triage Date: 10/24/03 Triage Time: 01:08
Triage Nurse: Wells, Kelley H
PMD: hooks
Who to see: Wants EMS to see

Mode of Arrival: Ambulatory

Transferred From:

Chief Complaint:

tripped on phone cord while working, c/o left side pain along with nausea; also c/o left arm, wrist and bilateral knee pain; denies hitting her head

Allergies:

ct contrast, sulfa, Td

GCS:

RTS:

Acuity Level: 1

Temp/Route	Pulse	Resp	BP	O2Sat/Modality	Weight (Kg)
Oral	70	20	111 74		Kg
Pain?	Level/Scale Used	Goal	Location	Character	Interventions
Yes	75 0-10		left side	Chronic	

Past Medical History:

Hypertension, Other: acid reflux and herniated disc

Medications:

(tenormin, 25mg, bid, po,)(cardizem cd, qd, po,)(acifex, , po,)(ultram, , prn,)(bextra, , ,)(xanax, , prn, ,)

Immunizations UTD: Yes

Tetanus: < 5 years

Influenza: Unknown Date:

Pneumovax: Unknown Date:

Head Circumference:

Communication Barriers: None evident

LMP: 10/01/2003 Pregnant: No

EDC:

GYN Status:

Triage Interventions

Prehospital Interventions:

Triage Interventions:

Glucose Screen:

Labs:

Tylenol PO:

Resp. Tx:

Ibuprofen PO:

Law Enforcement Called:

Visual Acuity:

Orthostatics:

L 20/ Corrected:
R 20/
B 20/ Corrective Lenses:

Lying Sitting Standing
BP: / BP: / BP: /
P: P: P:

Latex Screen

History of Latex Allergy Diagnosis? No

Carry an EpiPen or Anaphylaxis Kit?

Problem/Allergic Reaction to Rubber Products? No

If yes, type of reaction:

Medical Condition Requiring Many Surgical Procedures? No

If yes, describe:

History of Spina Bifida? No

Allergic Reaction to Any Foods? No

Unexplained Allergic Reaction During Medical or Dental Procedure? No

If yes, describe:

Date/Time

PROGRESS NOTES

19/04/03 0150

pt of pain to back & vaginal
area. States tapping over the phone
and at 0800 am of pain on phone.
Also ch of pain by (B)

0350

States fully better. DR about to
go to the understanding of instructions
and DR in out. Care. - R

Discharge Disposition

Time: 0350

Admit

☒ Home ☐ Other _____ Accompanied with ☒ Self ☐ Family ☐ EMS
Via ☐ W/C ☒ Ambulatory ☐ Stretcher ☐ Carried ☐ In Custody
Assessment of c/c: ☒ Improved ☐ N/C Pain Level _____
☐ Pt/S.O. verbalized understanding of discharge instructions _____

Time Report Called _____ Transported with:
Room # _____ ☐ Monitor ☐ O₂
Report to _____ ☐ Pulse Ox ☐ RN
Time to Floor _____

Initials

Signatures

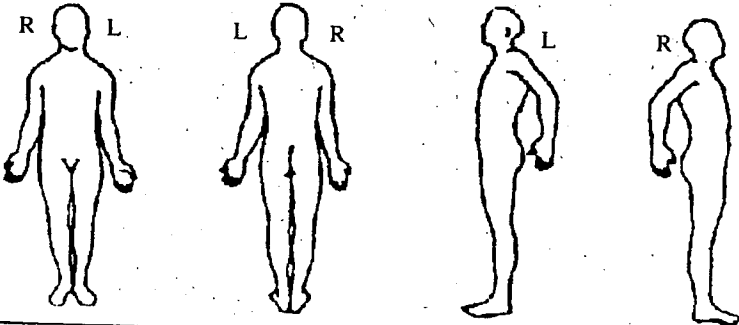
Initials

Signatures

BL B. L. L. L.

(464)

SIGNATURE

Respiratory	Cardiovascular ☐ N/A	Neurological	Abdominal ☐ N/A																	
irway Clear Obstructed Oral/Nasal Trach espirations Spontaneous Labored Assist Absent Hyperventilation Shallow Retractions Flaring each Sounds Clear Equal, Bilaterally Rales _____ Rhonchi _____ Wheezes _____ Decreased _____ Absent _____ ugh Productive Nonproductive Sputum _____ Nasal congestion thopnea # of pillows _____	☐ Rhythm ☐ Regular ☐ Irregular ☐ Paced ☐ Neck Veins ☐ Flat @ 45° ☐ Distended Circulatory ☐ Color ☐ Pink ☐ Pale ☐ Mottled ☐ Cyanotic ☐ Jaundiced ☐ Capillary Refill ☐ Normal ☐ Delayed R 2+ Pulses radial 2+ pedal _____ femoral _____ L 2+ ☐ AV Shunt ☐ Location _____ ☐ Thrill ☐ Yes ☐ No ☐ Bruit ☐ Yes ☐ No	☐ LOC ☒ Awake ☒ Alert ☐ Drowsy ☐ Restless ☐ Lethargic ☐ Unresponsive ☐ Orientation ☒ Time ☒ Place ☒ Person ☐ Speech ☐ Clear ☒ Slurred ☐ Aphasic ☐ Sensory ☒ No Deficits ☐ Numbness _____ ☐ Tingling _____ <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th></th> <th>Strong</th> <th>Weak</th> <th>Absent</th> </tr> </thead> <tbody> <tr> <td>RA</td> <td rowspan="4" style="text-align: center; vertical-align: middle;">2</td> <td></td> <td></td> </tr> <tr> <td>LA</td> <td></td> <td></td> </tr> <tr> <td>RL</td> <td></td> <td></td> </tr> <tr> <td>LL</td> <td></td> <td></td> </tr> </tbody> </table>		Strong	Weak	Absent	RA	2			LA			RL			LL			☐ Appearance ☐ Flat ☐ Rounded ☐ Distended ☒ Soft ☐ Other _____ ☐ Bowel Sounds ☒ Present ☐ Absent ☐ Palpation ☐ Mass _____ ☐ Tender _____ ☐ Guarding _____ ☐ Last BM _____ Genitourinary ☐ N/A ☐ Flank Pain _____ L _____ R ☐ Dysuria ☐ Hematuria ☐ Anuria ☐ Frequency ☐ Urgency ☐ Penile Discharge Color _____ GYN ☐ N/A ☐ LMP _____ ☐ Pre-g. _____ wks. G _____ P _____ Ab _____ FHT: ☐ Yes ☐ No Location _____ ☐ Vag. bleed _____ pads/ ☐ Vag. D/C ☐ Color _____
	Strong	Weak	Absent																	
RA	2																			
LA																				
RL																				
LL																				
Integumentary emperature Normal Warm Cold Hot Dry Diaphoretic gor Elastic Tenting ma Resent Absent Itching _____ Location _____ ous Membranes Moist Icky Dry	Musculoskeletal ☐ N/A 1. Abrasion 2. Amputation 3. Bleeding 4. Burn 5. Fracture 6. Gunshot 7. Laceration 8. Contusion 9. Redness 10. Pain 11. Paralysis 12. Penetr. Wound 13. Sprain 14. Tenderness 15. Swelling 16. Deformity 17. Ltd. Movement 18. _____ front back 	Vision ☒ N/A Visual Acuity L 20/____ R 20/____ Both 20/____ ☐ Correction ☐ Blurred L R ☐ Blind L R ☐ Drainage Present L R	Social History ☐ Eye contact ☐ Yes ☐ No ☐ Affect ☐ Flat ☐ Normal ☐ Speech ☐ Appropriate ☐ Inappropriate ☐ Appearance ☐ Clean ☐ Unkempt ☐ Other _____ ☐ Motor behavior ☐ Cooperative ☐ Restless ☐ Agitated ☐ Confused ☐ Hostile ☐ Support Systems ☐ Lives alone ☐ Family / S.O. ☐ Nursing Home ☐ Homeless ☐ Assisted Living ☐ Able to: ☐ Read ☐ Write																	
Breakdown (REQUIRED) Present ☐ Absent Location _____ Drainage _____ Routinely screening for domestic violence. Been hit, kicked, verbally or sexually by a family member or significant other? Yes ☐ No ☐ Need help with this today? Yes ☐ No ☐	Psychiatric ☐ Ideations ☐ None ☐ Harm to Self ☐ Harm to Others ☐ Security Notified ☐ Yes - Time _____ ☐ No ☐ Abuses ☐ None ☐ Alcohol ☐ Drug ☐ Inhalants ☐ Tobacco _____/day ☐ Hallucinations ☐ Auditory ☐ Visual ☐ Belongings Search Done																			

INTERVENTIONS

☒ Side Rails Up _____

☐ O2 @ _____

☐ Cardiac Monitor ☐ Initial Rhythm _____

☐ FSP ☐ OA ☐ C-collar _____ ☐ Backboard _____

Cleared By: _____

☐ Pulse Oximeter ☐ Spot check _____ ☐ Cont. _____

☐ NG/OG _____

☐ Restraints ☐ UE ☐ LE

***See Restraint Flowsheet**

Labs ☐ N/A

☐ CBC ☐ Amylase/Lipase

☐ BMP ☐ Cardiac Enz.

☐ PTT/PTT ☐ Blood C&S

☐ Mg ☐ T X C _____ units

☐ GC/Chlamydia ☐ Troponin

☐ ABG ☐ Other _____

☐ UPT

☐ U/A via ☐ Bag ☐ I/O ☐ CC ☐ Foley

☐ Redraw

☐ Hold Tubes: ☐ Red ☐ Green ☐ Blue ☐ Lavender

EKGs ☐ N/A

☐ EKG 12 lead _____ ☐ EKG 12 lead _____

☐ EKG 12 lead _____ ☐ EKG 12 lead _____

IV

Time	Gauge	Site	By	# Attempts	Time	DC'd W/O Complications	By

X-Rays ☐ N/A

Time _____ Time _____

C-Spine ☐ CT scan

☐ port _____ ☐ Head ☐ Chest ☐ Abdomen

☐ comp _____ ☐ U/S _____

☐ C X R ☐ Special Procedure _____

☐ port _____ ☐ Other _____

☒ PA & Lat _____

☐ Abdomen

☒ Upper Ext. *Distal* ☐ Lower ext. _____

Medications Estimated Weight: _____

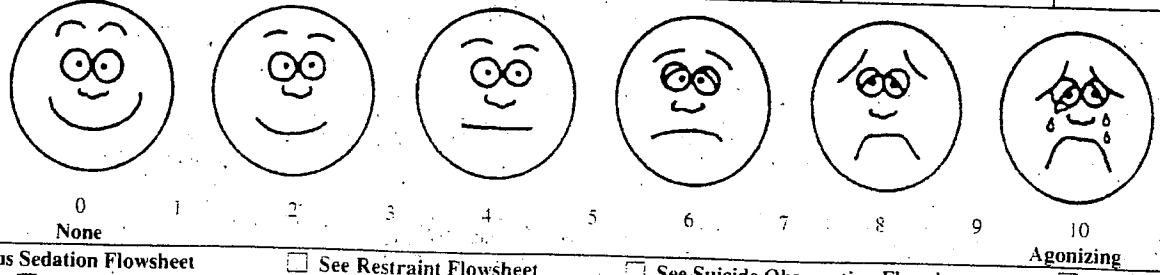
Time	Drug/Dose/Route/Site	Given By	Response
2:15 PM	400 mg PO	BP	

Medications

Time	Drug/Dose/Route/Site	Given By	Response

PAIN ASSESSMENT

Date	Time	Pain Level	Location	Quality	Intervention	Initials	Time	Post Intervention Pain Level	Action	Initials



☐ See Conscious Sedation Flowsheet ☐ See Restraint Flowsheet ☐ See Suicide Observation Flowsheet ☐ See continued RN Notes

Resource Needs: ☐ None ☐ Financial Counselor ☐ Sistercare

☐ Social Worker ☐ Assistance with ADL's ☐ Sexual Trauma Service

☐ Clinical Counselor ☐ Assistance with Referral ☐ Other

☐ Assistance Getting Medications

(466)

PALMETTO RICHLAND AND MEMORIAL HOSPITAL EMERGENCY CENTER AFTERCARE INSTRUCTIONS

SHIVER, GERTRUDE
0329700191
MR 009952117 EMS, EMS
05/19/54 49Y F


YOUR DIAGNOSIS TODAY IS: Date: 10/24/03

Minor Contusions to chest wall, knee + @ wrist

ADDRESSOGRAPH

If you are worried about your illness and your doctor cannot be contacted, Palmetto Richland Memorial Emergency Services is available for emergency care. You may call or return to the emergency department. Phone # 434-6350.

Follow-up Care / Referral As Need

Arrange for an appointment in _____ days with:

☐ Private Doctor: _____

Phone Number: _____

☐ Ambulatory Clinic

Call 434-4100 for appointment

- | | |
|--|--------------------------------------|
| ☐ Medicine | ☐ Orthopedic |
| ☐ Family Practice | ☐ Pediatric |
| ☐ Obstetrics/Gynecology | ☐ Other _____ |



☐ Emergency Department for further concern

Call sooner if not improving or if there is any problem.
Until you contact your follow-up doctor,
follow instructions as directed.

MEDICATIONS GIVEN TO YOU IN THE ER:



- | | | |
|---|-----------------------------------|---|
| ☐ Tylenol | ☐ Rocephin | ☐ Dilantin |
| ☒ Ibuprofen | ☐ Toradol | ☐ Lidocaine |
| ☐ Benadryl | ☐ Floxin | ☐ Mylanta/Donnagel |
| ☐ Tetanus | | |
| ☐ Other _____ | | |

Medications Prescribed for you today are:

Drug Name	Used for
<u>Motrin</u>	<u>pain</u>
<u>Pheneyan</u>	<u>nausea</u>

Additional Medications / Instructions:

- ☐ Take all antibiotics as directed and until all medicine is gone.
- ☐ Do not drink alcohol, drive or operate machinery while taking this medication.
- ☐ Follow-up visit needed after completion of antibiotics in _____ weeks with private MD.



- ☒ Take medications with food.
- ☐ If rash, shortness of breath, or excessive vomiting occurs - stop medications and notify your MD or return to ER.
- ☐ If there is no improvement after taking antibiotics for 72 hours - contact your private MD.
- ☐ _____

TEST RESULTS:

☒ Your x-rays have been read by the ER Doctor. They will also be reviewed by our radiologist. If any other problems are found that have not been called to your attention, you will be notified.

☐ Cultures require 48-72 hours for final reading. You may call 434-3311 for results.

☐ Pick up x-rays (x-ray file room)

Over the counter medications you need to take are:

- ☐ Tylenol _____ every 4-6 hours as needed for fever or pain
- ☐ Ibuprofen (e.g.: Motrin, Advil) _____ every 6 hours as needed for fever or pain. Take with food.
- ☐ Benadryl _____ every 6 hours as needed for itching.
- ☐ _____

FACT SHEETS GIVEN:



Other Instructions: Discharged home. Use Motrin
prescription as directed. Return for worsening
Follow-up with primary doctor if no better
in 1 week

I have received and understand the above instructions for aftercare. I understand that I have had emergency treatment only, which is not a substitute for continuing medical care. I will arrange for follow-up care as instructed.

Nurse: [Signature]

☐ INT D/C

Patient/
Family: [Signature]

(467)

**MIDLANDS INTERNAL MEDICINE
OFFICE VISIT NOTE**

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/25/03

*Severe pain
shoulder joint*

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain as well as left ankle pain, who basically presents for follow-up of her medical problems. The patient unfortunately has suffered another fall, most recently on 10/23/03. Apparently she tripped over a phone cord at work and landed on her left side. She was sent to her nursing supervisor and was evaluated by Dr. Durkan at Employee Health and apparently had some films performed, which revealed no rib fractures, etc. She continues to have some left rib pain nonetheless. She also notes that when she lies on her left side, she develops palpitations at night and this, at times, can be associated with mild nauseousness. She claims that she has also continued to have severe heel discomfort as well as foot discomfort. The patient was evaluated by numerous orthopedists including Dr. McBride at USC Specialty Clinics. Basically, her MRI was read as an abnormality about the flexor hallucis longus. However, her MRI was reviewed with Dr. McBride and it is felt that this is not a surgical situation, that it is not a post traumatic problem and that there are no further diagnostic or procedural studies or treatments that need to be done. The patient claims that she was somewhat frustrated with this diagnosis as her MRI was grossly abnormal. She actually went to see another doctor in Georgia, who basically gave her an ankle brace. The patient notes that she is still quite uncomfortable in her left foot and heel and she does note that she has continued strengthening and occasional icing indefinitely as well as stretching. Dr. McBride specifically suggested that heel counters in her left or right heel should not be used. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. Aciphex 20mg q day
9. Lortab prn (rare)

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/25/03

PAGE 2 of 3

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress, mildly anxious.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac and regular.

CHEST WALL: Significant discomfort to even light palpation in the lateral left rib area.

ABDOMEN: Obese but benign.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

MUSCULOSKELETAL: The patient does have pes planus. There is some tenderness throughout the hind foot and mid foot on the left. Otherwise, basically unremarkable.

ASSESSMENT AND PLAN:

1. Left ankle and heel pain as well as diffuse left foot pain. At this point, I cannot add much to the patient's work-up or diagnosis. I have encouraged her to perhaps follow-up with The Miller Clinic in Charlotte or The Houston Clinic in Columbus, Georgia and I have given her these addresses, as they are more specialty clinics directed towards the foot. However I would have to agree with Dr. McBride as I fully respect his opinion. She has also seen other orthopedists in town including Dr. Belding, who I respect as well and deals specifically with the feet. I will hold off on further work-up at this time and defer to her other subspecialists.
2. Palpitations. Again, the patient does have a history of paroxysmal supraventricular tachycardia. This only occurs when she lies on her left side. We cannot reproduce symptoms having her in this position. We will set up a Holter monitor over the next 24 hours and see how she does.
3. Nausea. The patient will be given Phenergan. I am unsure of the etiology. She has had a recent CT scan of the abdomen and pelvis, which was unremarkable.

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MIDLANDS INTERNAL MEDICINE

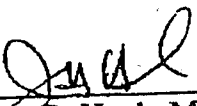
OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/25/03

PAGE 3 of 3

ASSESSMENT AND PLAN: (cont.)

4. Left chest wall pain. Likely due to bruised ribs. The patient did have recent rib films, which apparently were unremarkable. I have told her that this can take anywhere from six to eight weeks to completely resolve. She should continue her Bextra. I have also encouraged her to ice this area, perhaps even use a heating pad and we have also suggested she use her Ultram or Lortab as needed.
5. Reflux. Stable on Aciphex.
6. Routine health maintenance. Basically up to date.



Jeffrey D. Hook, MD

(470)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 12/15/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain as well as left ankle pain, who basically presents for follow-up of her medical problems. Since last being seen, the patient did go to The Miller Clinic in Charlotte and has basically been placed in an immobilization boot of her left ankle and heel. She notes that, if anything, this has been quite helpful. She continues to have problems with neck and back pain. She notes that she has not been down to The Spine Clinic in Charleston due to the fact that she claims that she owes them money as Workman's Comp has not paid them and she does not want to run up her bill. She continues to use Bextra on a daily basis with Ultram versus Lortab prn. She otherwise has felt relatively well since placing a Holter monitor on her for palpitations. She has been palpitation free. Again, her Holter monitor was completely normal. She notes that her reflux has tremendously improved with Aciphex and has cut this down to as needed. She is having no difficulty swallowing. She really has very little in the way of complaints, other than chronic pain.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. Aciphex 20mg q day prn
9. Lortab prn (rare)

REVIEW OF SYSTEMS: The patient still notes occasional episodes of mild abdominal discomfort. Again, she has had a CT scan of the abdomen and pelvis within the last year, which was completely unremarkable. All other systems reviewed at this time and negative.

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 12/15/03

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress, mildly anxious.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Regular.

ABDOMEN: Obese but benign.

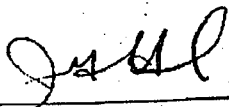
EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

MUSCULOSKELETAL: Again, left ankle in an immobilization boot.

ASSESSMENT AND PLAN:

1. Left ankle and heel pain as well as diffuse left foot pain. The patient actually saw the PA at The Miller Clinic, who immobilized her ankle. She has noted improvement thus far. She will go back and see one of the physicians there in a few weeks.
2. Chronic neck and back pain. Continue to follow with The Spine Clinic. We will continue her Bextra and prn Ultram versus Lortab. Obviously we have encouraged more in the way of Ultram due to its lesser addictive potential.
3. Palpitations. The patient has a history of paroxysmal supraventricular tachycardia. Her Holter monitor has been negative and she has been asymptomatic. Continue to follow.
4. Reflux. Continue Aciphex on an as needed basis.
5. Abdominal pain. Again, unknown etiology. However, CT scan of the abdomen and pelvis normal. This has not been as significant as it has been in the past.
6. Routine health maintenance. Basically up to date.



Jeffrey D. Hook, MD

(4727)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 03/29/04

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for complete physical exam. The patient notes that she is doing relatively well. She continues to have chronic back and neck pain and is followed by Carolina Spine Clinic in Charleston. She notes that she needs to go back there for an injection as oral medications are not necessarily helpful. She really has no other major complaints and otherwise feels relatively well.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995

reproductive system (normal)

ALLERGIES:

1. Tetanus caused severe edema and induration with pain
2. CT dye gave her hives and palpitations.
3. PPD caused hives and palpitations as well.

Skin (++)

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn, which is rare

SOCIAL HISTORY: The patient does not smoke, nor does she drink alcohol. She is not married and has no children and is currently not sexually active. She is originally from Gaston and lived in Charleston but has been in Columbia since 1998. She was a cardiac nurse but became disabled due to back pain. She now works in Medical Records for Richland Memorial Hospital and notes a moderate amount of stress. She puts in about 40 hours a week.

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**MIDLANDS INTERNAL MEDICINE
PHYSICAL EXAMINATION**

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 03/29/04
PAGE 2 of 3

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90. She had diabetes, dementia, and a stroke in the end as well. She denies any overwhelming amount of heart disease in the family but does note hypertension and strokes. She also notes diabetes. There is a history of breast cancer in the family and her sister had colon cancer in her 50's. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is fair. Her exercise is minimal.

REVIEW OF SYSTEMS: The patient does note occasional sinus headaches but these are minimal in nature. She gets her eyes checked yearly by Dr. Blake. She notes significant amounts of left-sided neck pain that, at times, radiates into her left shoulder and notes muscular tightness. Skelaxin and Ultram do seem to be somewhat helpful. She notes fluctuating bowel habits, mostly with constipation. Seems to be worsened on Ultram. She did have a colonoscopy in 2002 and interestingly did have an adenomatous polyp that will need to be repeated. She notes diffuse abdominal and pelvic pain. She continues to have ankle pain and was evaluated by the Miller Clinic. She notes some insomnia. She notes some fatigue. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round and reactive to light and accommodation. Extra-ocular movements intact. Funduscopic exam unremarkable.

TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No lymphadenopathy. No thyromegaly. No bruits.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. There are no murmurs, rubs, or gallops auscultated.

ABDOMEN: Soft, nondistended. There is mild tenderness diffusely. There are positive bowel sounds in all quadrants. There is no hepatosplenomegaly or mass.

BREASTS: No dominant masses. Mild fibrocystic changes. Some scar tissue from previous mastoplasty. No nipple inversion. No skin dimpling. No axillary nodes.

UROGENITAL: The patient has normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable. Perhaps some mild irregularity to the uterus.

RECTAL: No masses. Normal sphincter tone. Guaiac negative stool.

EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

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MIDLANDS INTERNAL MEDICINE

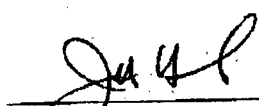
PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 03/29/04

PAGE 3 of 3

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Continue current regimen. The patient seems to be extremely well controlled. She did have a recent Holter monitor, which was normal. EKG was not repeated today.
2. Reflux with overlapping stricture, status post dilation. Continue Aciphex on a daily basis.
3. Adenomatous polyp. Will call the patient in May for repeat colonoscopy as she is due this year.
4. Neck pain. Needs to go back to Charleston Spine Institute, where she is also followed for her chronic back pain.
5. Abdominal discomfort. The patient did have a CT scan but this was done without contrast. We will try ultrasound of the pelvis and abdomen for further evaluation.
6. Fatigue. Will check endocrinologic and metabolic etiologies.
7. Diffuse arthralgias. Again, consider rheumatologic panel in the future.
8. Routine health maintenance. Have encouraged increasing exercise, perhaps non weight bearing, for instance an exercise bike. She is otherwise completely up to date.


Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/19/04

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who presents for follow-up of her medical problems. The patient was having some vague pelvic pain at her last visit. Her pelvic exam was basically unremarkable. Nonetheless, she had a pelvic ultrasound performed which revealed fibroids throughout the uterus and two cysts on the right ovary. One perhaps was septated. The other appeared to be simple. With these findings, she was referred to OB-GYN. Dr. Odom has since evaluated her and will follow with her closely. He did claim that one of the options was hysterectomy but he does not feel that this is necessary. He will be following up her ovarian cysts. The patient notes that her biggest complaint continues to be that of neck and back pain. She is going to go to Charleston to the Carolina Spine Institute, where she has been seen in the past. The patient also continues to have some left ankle instability. She went back to Charlotte for further evaluation and they basically did not change her regimen. She has since been using an immobilizer/brace on her left ankle, which has provided some support but she still has some discomfort. She has no other major complaints and otherwise has felt relatively well.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.
ALLERGIES: Unchanged since previously documented in the chart.
MEDICATIONS: Unchanged since previously documented in the chart.
SOCIAL HISTORY: Unchanged since previously documented in the chart.
FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn, which is rare

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

(476)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/19/04

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2.

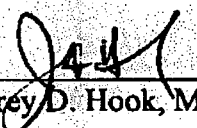
ABDOMEN: Benign, other than mild tenderness diffusely.

EXTREMITIES: No edema. Left ankle brace in place.

NEUROLOGICAL: Intact.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Continue current regimen. She seems to be well controlled in this regards.
2. Reflux with overlapping stricture status post dilation. Continue Aciphex.
3. Adenomatous polyp. Will call the patient in May for repeat colonoscopy as she is due this year.
4. Neck and low back pain. Continue to follow with Charleston Spine Institute.
5. Abdominal discomfort. Perhaps related to her ovarian cysts. She will follow-up with Dr. Odom.
6. Routine health maintenance. Otherwise up to date.


Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/16/04

The patient is a 50-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who presents for follow-up of her medical problems. The patient claims that she continues to have left rib pain status post a fall in October. This has been somewhat frustrating for her. She also notes that she has now developed some mild headaches, which seem to radiate from the cervical spine up into the occipital region and at times feels as though it is band-like in nature. She also notes that she has had some nerve blocks followed by facet blocks by the Charleston Spine Institute in Charleston. This has been somewhat helpful. Her left ankle pain has been braced. She is followed in Charlotte and this has been somewhat helpful, even though she continues to have some discomfort. She also notes that she has developed some right hand and arm numbness and "shock-like" sensation. She notes her entire hand, she feels, is involved as well as her arm. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.
ALLERGIES: Unchanged since previously documented in the chart.
MEDICATIONS: Unchanged since previously documented in the chart.
SOCIAL HISTORY: Unchanged since previously documented in the chart.
FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn.

REVIEW OF SYSTEMS: The patient did undergo laparoscopic left ovarian cystectomy. However, due to severe adhesions involving the left ovary, tube, and posterior fundus of the uterus and bowel, this could not be done. These were felt to be due to her previous myomectomy. She continues to have some left lower quadrant discomfort. All other systems reviewed at this time and negative.

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/16/04

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits. There is some tightness in the trapezius muscles.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2.

CHEST WALL: The patient has moderate left lateral rib discomfort to deep palpation.

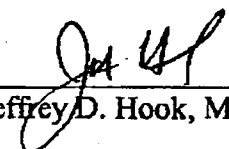
ABDOMEN: Benign, other than mild tenderness diffusely.

EXTREMITIES: No edema. Left ankle brace in place.

NEUROLOGICAL: Intact. Negative Tinel and Phalen sign.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Continues to be asymptomatic. We will keep her on her current regimen.
2. Reflux with overlapping stricture status post dilation. Continue Aciphex. She is not necessarily symptomatic in this regards.
3. Adenomatous polyp. The patient did undergo repeat colonoscopy. This was negative.
4. Headaches. Likely due to tension type headaches. I have encouraged her to try the Skelaxin when this occurs.
5. Left rib pain. Again, status post a fall in October of 2003. We will obtain rib films, even though she had original negative rib films in the past.
6. Right hand "shocks." Likely due to her disc disease in the neck. She does not necessarily have signs of carpal tunnel syndrome or ulnar neuropathy. We will follow.
7. Left ankle pain. Continue to wear left ankle brace and follow-up in Charlotte.
8. Abdominal discomfort. Persistent. Noted to have adhesions. Will follow-up with Dr. Odom.
9. Low back pain. Again, improved with nerve blocks. Followed by facet blocks at Charleston Spine Institute.
10. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/19/04

The patient is a 50-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents with new onset of rash. The patient notes that she has had an extremely pruritic rash on the back of her neck. She denies any new exposures, such as detergents, soaps, jewelry, etc. She claims that it is limited to the back of her neck. She also notes that her left nipple has been itching but she sees no rash there. She denies any discharge or mass. She has no other major complaints and otherwise has been doing relatively well. She has been followed by The Miller Clinic in Charlotte and has had some injections performed to her left ankle and she does note some improvement in this regards. She has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.
ALLERGIES: Unchanged since previously documented in the chart.
MEDICATIONS: Unchanged since previously documented in the chart.
SOCIAL HISTORY: Unchanged since previously documented in the chart.
FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn.

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/19/04
PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2.

BREASTS: No palpable masses. No nipple inversion. No nipple discharge. No visible rash. Minimal fibrocystic change. No axillary nodes. No skin dimpling.

ABDOMEN: Benign

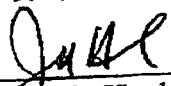
EXTREMITIES: No edema.

NEUROLOGICAL: Intact.

SKIN: Macular erythematous rash on the posterior aspect of the neck. It is nonvesicular, minimally raised, and somewhat excoriated.

ASSESSMENT AND PLAN:

1. Rash. Appears to be a contact dermatitis. I have given the patient some Olux foam to use on a daily basis. The patient was encouraged to pay closer attention to any new exposures. If she is not seeing any improvement, consider dermatologic consultation. She was also told that she could use oral Benadryl if needed, which would likely help with some of the itching. We will follow.
2. Left nipple itching. Again, no rash is visible. It does not appear that this is related to the rash that she has on the back of her neck. Her exam is unremarkable. She is up to date on mammogram. I have reassured her in this regards.
3. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
4. Reflux. Continue Aciphex.
5. Right hand "shocks." Again, continues. Likely due to disc disease in her neck.
6. Left ankle pain. Again, has improved with injections by The Miller Clinic in Charlotte.
7. Abdominal discomfort. This has been persistent and felt to be due to adhesions.
8. Low back pain. Again, improved with nerve blocks. Followed by facet blocks at Charleston Spine Institute.
9. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 12/20/04

The patient is a 50-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who presents for follow-up of her medical problems. The patient notes that her ankle is still giving her problems. She is followed by the Miller Clinic in Charlotte and notes that it is improved status post injections but still not where she thinks it should be. She also continues to have left rib cage discomfort in the intercostal region. This has been giving her more and more discomfort. She seems to find that this does not respond to anti-inflammatories or Ultram as well. She really has no other major complaints. She has been basically palpitation free as well as reflux free, as long as she continues her Aciphex. She has very little in the way of complaints, other than that.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn.

REVIEW OF SYSTEMS: The patient did have rib films performed at the last visit and they were basically unremarkable. All other systems reviewed at this time and negative.

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 12/20/04

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2.

CHEST WALL: Moderate intercostal rib cage pain in the left lateral rib cage, radiating around into the right anterior rib cage.

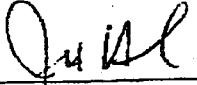
ABDOMEN: Completely benign

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
2. Reflux. Continue Aciphex.
3. Degenerative disc disease. Again, known in her neck and lumbosacral spine. She continues to follow with the Carolina Spine Clinic in Charleston.
4. Left ankle pain. Follows with the Miller Clinic in Charlotte.
5. Left-sided intercostal rib pain. Will send her to Pain Management to see if perhaps injections or manipulation would be helpful.
6. Abdominal discomfort. Again, this has been persistent. Felt to be due to adhesions.
7. Routine health maintenance. Basically up to date.


Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/15/05

The patient is a 50-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, chronic back and neck pain, left ankle pain, and left chest wall pain, who basically presents for complete physical exam. The patient has been evaluated by Dr. Brandt at the Pain Management Center and basically suspects that the patient has intercostal neuralgic pain and has basically performed intercostal nerve blocks on the left at T3 through T8, has placed her on Gabitril, and also has given her Lidoderm patches. She notes that this has improved her discomfort level but she does continue to have some discomfort. She otherwise has generally felt relatively well. She was recently seen at the Miller Clinic in Charlotte regarding her left ankle and received an injection there as well, which has been extremely effective. She really has no other major complaints.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995
3. Laparoscopic lysis of adhesions by Dr. Odom last year.

ALLERGIES:

1. Tetanus caused severe edema with induration.
2. CT dye has given her hives and palpitations.
3. PPD caused hives and palpitations.
4. Questionably sulfa (unknown reaction)

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day (switching to Mobic 15mg q day)
4. Baby aspirin q day
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. AcipHex 20mg q day
9. Maalox for breakthrough
10. Lortab prn (extremely rare)
11. Gabitril 4mg q HS
12. Lidoderm, 12 hours on and 12 hours off

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MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/15/05

PAGE 2 OF 4

SOCIAL HISTORY: The patient does not smoke, nor does she drink alcohol. She is not married and has no children, and is currently not sexually active. She is originally from Gaston and has lived in Charleston but has resided in Columbia since 1998. She was a cardiac nurse but became disabled due to back pain. She now works in Medical Records for Palmetto Richland and notes mild stress. She puts in about 40 hours a week. In her free time, she basically reads and is currently taking a course for medical transcription.

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90 with underlying diabetes, dementia, which is felt to be multi-infarct. She denies any overwhelming amount of heart disease in the family but does note hypertension and stroke. She also notes diabetes. There is a history of breast cancer in her family as well as a sister who had colon cancer in her 50's. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is relatively poor. Her exercise is minimal.

REVIEW OF SYSTEMS: The patient is up to date on eye exam by Dr. Blake. She does get occasional breakthrough from her reflux and will have to add Maalox, which seems to help with her symptoms. This is generally due to dietary indiscretion. She continues to have moderate neck and low back pain and is followed at The Spine Clinic in Charleston. Her left ankle and heel have been followed by The Miller Clinic in Charlotte. Her left costochondral chest wall pain has been followed by Dr. Brandt. Full work-ups, including multiple MRI's, bone scans, etc. have been negative. The patient does note a mild fatigue. She notes a rare palpitation but this has basically been well controlled. She did have an unremarkable Holter monitor approximately one year ago. All other systems reviewed at this time and negative.

PHYSICAL EXAM: Vital signs noted:

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light and accommodation. Extraocular movements intact. Funduscopic exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No bruits. No lymphadenopathy. No thyromegaly.

LUNGS: Clear to auscultation and percussion bilaterally.

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MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/15/05

PAGE 3 OF 4

PHYSICAL EXAMINATION: (cont.)

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. No murmurs, rubs, or gallops auscultated.

~~CHEST WALL: Left-sided chest wall pain improved but present.~~

BREASTS: No dominant masses. Mild fibrocystic changes. Scar tissue noted from previous mammoplasty. No nipple inversion. No skin dimpling. No axillary nodes.

ABDOMEN: Soft, nondistended. Mild tenderness diffusely. Positive bowel sounds in all quadrants. No hepatosplenomegaly or mass.

UROGENITAL: Normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable.

RECTAL: Normal sphincter tone. No palpable masses. Guaiac negative stool in the vault.

EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS: EKG was obtained and reveals a sinus bradycardia. There are no significant STT wave abnormalities.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. For the most part, asymptomatic on current regimen.
2. Reflux. Continue AcipHex with prn Maalox.
3. Degenerative disc disease. Known in her neck and lumbosacral spine. She will follow with Carolina Spine Clinic in Charleston. Will change her Bextra to Mobic 15mg q day
4. Left ankle pain. Follows with The Miller Clinic in Charlotte.
5. Left-sided intercostal rib pain. Felt to be neuralgic in nature. She has seen improvement with Pain Management. Will follow with Dr. Brandt or Zgleszewski.
6. Abdominal discomfort. Has been persistent but improved since lysis of adhesions. Will continue to follow along with Dr. Odom.

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MIDLANDS INTERNAL MEDICINE

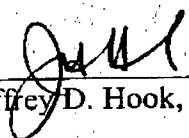
PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/15/05

PAGE 4 OF 4

ASSESSMENT AND PLAN: (cont.)

7. Fatigue. Will check all endocrinologic and metabolic markers.
8. Routine health maintenance. Basically up to date. The patient had repeat colonoscopy in June of 2004 and will not need to be rescreened for 5 years. She is still having periods and we will not get a baseline DEXA at this time, until she is postmenopausal. She was strongly encouraged to increase her cardiovascular exercise regimen, watch her diet more thoroughly and perhaps lose some weight, as this has been trending upwards. We will continue to follow her closely.



Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/21/05

The patient is a 51-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, chronic back and neck pain, left ankle pain, and left chest wall pain, who basically presents for follow-up of her medical problems. The patient notes that she is doing extremely well in all facets, except for her pain. She continues to have moderate amounts of neck and low back pain, as well as intermittent intercostal neuralgic pain. She actually has an appointment to go back and see Dr. Brandt now at his Lugoff office. She is taking occasional Ultram, which she feels as though is somewhat helpful. She has noted some improvement in her left ankle pain. She has gone back to the Miller Clinic in Charlotte and has had another injection there as well. She denies any palpitation, shortness of breath, nausea, or vomiting. She claims that her bowel habits are regular and is having no urinary symptoms as well. She otherwise feels reasonably well, other than the pain.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.
ALLERGIES: Unchanged as previously documented in the chart.
MEDICATIONS: Unchanged as previously documented in the chart.
SOCIAL HISTORY: Unchanged as previously documented in the chart.
FAMILY HISTORY: Unchanged as previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Mobic 15mg q day
4. Baby aspirin q day
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. AcipHex 20mg q day
9. Maalox prn breakthrough
10. Lortab prn (extremely rare)
11. Gabitril 4mg q HS
12. Lidoderm, 12 hours on and 12 hours off (minimal)

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/21/05

PAGE 2 OF 2

PHYSICAL EXAM: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac but regular.

CHEST WALL: Left-sided chest pain present with deep palpation. Improved but still minimally present.

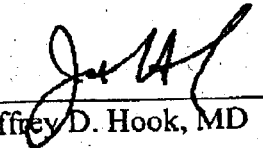
ABDOMEN: Obese but benign.

EXTREMITIES: No edema.

NEUROLOGIC: Nonfocal.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. For the most part, asymptomatic on current regimen.
2. Reflux. Continue AcipHex with prn Maalox.
3. Degenerative disc disease. Known in her neck and lumbosacral spine. She will continue to follow with Carolina Spine Clinics in Charleston. She will continue Mobic 15mg q day with Ultram for breakthrough.
4. Left ankle pain. Follows with the Miller Clinic in Charlotte. This has improved with local injections.
5. Left-sided intercostal rib pain. Felt to be neuralgic in nature. She will follow-up with Dr. Brandt. Continue Lidoderm as needed.
6. Abdominal discomfort. Has actually improved since lysis of adhesions with Dr. Odom.
7. Routine health maintenance. Completely up to date. We have encouraged more cardiovascular exercise regimen with better dietary habits and weight loss. We will follow closely.


Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/15/06

The patient is a 51-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilatation times two, chronic back and neck pain, left ankle pain, and left chest wall pain, who basically presents with complaints of acute onset of left ear pain times one week and recent complaints of nausea, vomiting, and diarrhea. The patient claims that symptoms began approximately one week ago with left ear pain. She has used Hydrogen Peroxide in her ear, which she claims has given her little benefit. She notes that the ear feels clogged, as though there is fluid behind it. She claims that she may have had some low grade fever, even though she did not check her temperature. This persisted until the weekend, when she suddenly developed nausea, vomiting, and loose stool. This was associated with some abdominal cramping but without any significant pain. She denies any hematochezia, dark or tarry stool, or frank blood. She has felt somewhat weak, as she has not been able to eat due to the nausea. She has been trying to increase her fluid intake, actually with orange juice. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.
ALLERGIES: Unchanged as previously documented in the chart.
MEDICATIONS: Unchanged as previously documented in the chart.
SOCIAL HISTORY: Unchanged as previously documented in the chart.
FAMILY HISTORY: Unchanged as previously documented in the chart.

REVIEW OF MEDICATIONS:

- ✓ 1. Cardizem CD 120mg q day (branded)
- ✓ 2. Tenormin 25mg bid (branded)
- ✓ 3. Mobic 15mg q day
- ✓ 4. Baby aspirin q day
- ✓ 5. Tylenol prn
- ✓ 6. Skelaxin prn
- 7. Ultram prn (Ultram 100mg qd)
- ✓ 8. AcipHex 20mg q day
- ✓ 9. Maalox prn
- 10. Lortab prn (....)
- ø 11. Gabitril 4mg q HS
- ✓ 12. Lidoderm prn →

(Lidoderm 100g bid)

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/15/06
PAGE 2 OF 2

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

PHYSICAL EXAM: Vital signs noted. The patient is afebrile.

GENERAL: In no acute distress.

HEENT: Mild serous fluid seen behind the left TM. Right TM clear, otherwise unremarkable.

NECK: No JVD. No bruits. No lymphadenopathy.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac.

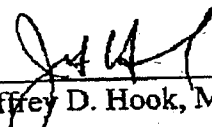
ABDOMEN: Obese, soft, nontender. There are slightly hyperactive bowel sounds. No hepatosplenomegaly or mass.

EXTREMITIES: No edema.

NEUROLOGIC: Nonfocal.

ASSESSMENT AND PLAN:

1. Serous otitis media. Will treat the patient with Duraphen Forté, ½ tablet bid. I doubt that this will affect her paroxysmal supraventricular tachycardia. She was also given some Zoto Otic HC drops to use on an as needed basis.
2. Viral gastroenteritis. Will treat the patient with Phenergan 25mg q 4 to 6 hours prn nausea. She was also given some Levsin sublingual to use for cramping. I told her that I do not want her to use any antidiarrheals, as this is the body's mechanism to get rid of the underlying virus. If she develops any significant abdominal pain, etc., she will let me know. She was given an excuse to miss today and tomorrow of work.
3. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
4. Reflux. Continue AcipHex with prn Maalox.
5. Degenerative disc disease. Known in her cervical and lumbosacral spine. Continue Mobic with prn Ultram.
6. Left-sided intracostal rib pain. Felt to be neuralgic in nature. She will continue Lidoderm as needed.
7. Routine health maintenance. Otherwise up to date.


Jeffrey D. Hook, MD

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MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/21/06

The patient is a 51-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, chronic back and neck pain, left ankle pain, and left chest wall pain felt to be neuralgic in nature, who basically presents for complete physical exam. The patient's biggest complaint at this time continues to be left-sided intercostal rib pain. This is felt to be neuralgic in nature. She is following with Dr. Brandt of Pain Management. She is currently using a topical Lidoderm patch, which seems to be helpful. She has been placed on Lyrica, which she is now using on an as-needed basis, as regular use did cause some oversedation. Other than her pain, she feels as though she is doing reasonably well. She has very little in the way of other complaints.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995
3. Laparoscopic lysis of adhesions by Dr. Odom in 2004

ALLERGIES:

1. Tetanus caused severe edema with induration localized
2. CT dye has given her hives and palpitations.
3. PPD caused hives and palpitations.
4. Questionably sulfa drugs (unknown reaction)

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day (branded)
2. Tenormin 25mg bid (branded)
3. Mobic 15mg q day
4. Baby aspirin q day
5. Tylenol prn
6. Skelaxin prn
7. Ultram CR 100mg q day
8. AcipHex 20mg q day
9. Maalox prn
10. Lortab prn (rare)
11. Lyrica 100mg bid
12. Lidoderm, 12 hours on and 12 hours off

(492)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/21/06

PAGE 2 OF 4

SOCIAL HISTORY: The patient is not a smoker, nor does she drink alcohol. She is not married and has no children, and is not sexually active. She is originally from Gadsden and has lived in Charleston but has been back to Gadsden since 1998. She was a cardiac nurse but became disabled due to back pain. She currently works in Medical Records for Palmetto Richland and notes moderate stress. She puts in about 40 hours a week. She was planning on a medical transcription job but is having difficulty in getting hired for this.

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90 with diabetes, dementia, which is felt to be multi-infarct. She denies any overwhelming amounts of heart disease in the family but does note hypertension and occasional stroke. She also notes diabetes. There is a history of breast cancer in her family as well as a sister who passed away from colon cancer in her 50's. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is somewhat poor. Her exercise, she has been increasing this and has been going to a gym.

REVIEW OF SYSTEMS: The patient is up to date on eye exam with Dr. Blake. She does note, at times, some mild nausea. She is unsure what causes this but is generally short lived. She does have Phenergan available, if needed. She does have a tendency towards reflux, only if she overeats. She notes diffuse pain, most notably in her neck, low back, and rib cage. She was recently diagnosed with a peripheral neuropathy and has been undergoing Anodyne therapy. This has been helpful. She did have full peripheral neurology work-up. She continues to have some left ankle and foot pain but this has improved as well. She does note some rare constipation. She does feel somewhat fatigued. She has had no further palpitations and her blood pressure has been extremely well controlled. She really has no other major complaints. All other systems reviewed at this time and negative.

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MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/21/06

PAGE 3 OF 4

PHYSICAL EXAM: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light and accommodation. Extraocular movements intact. Funduscopy exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No bruits. No lymphadenopathy. No thyromegaly.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. No murmurs, rubs, or gallops auscultated.

CHEST WALL: Left-sided chest pain somewhat moderate in nature, diffusely through the left-sided chest wall.

BREASTS: No dominant masses. Mild fibrocystic changes. Scar tissue noted from previous mammoplasty. No nipple inversion. No skin dimpling. No axillary nodes. There is some tenderness but this appears to be more chest wall in nature, rather than breast in nature.

ABDOMEN: Soft, nondistended, nontender. Positive bowel sounds in all quadrants. No hepatosplenomegaly or mass.

UROGENITAL: Normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable.

RECTAL: Normal sphincter tone. No palpable masses. Guaiac negative stool in the vault.

EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS:

1. EKG was obtained and reveals a sinus bradycardia. There are no significant STT wave abnormalities.
2. Urinalysis unremarkable.

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MIDLANDS INTERNAL MEDICINE

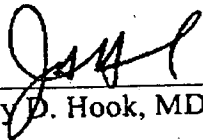
PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/21/06

PAGE 4 OF 4

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
2. Hypertension. Extremely well controlled.
3. Reflux. Continue AcipHex with prn Maalox.
4. Degenerative disc disease with findings positive in the cervical and lumbosacral spine. She will continue with Mobic 15mg daily, as well as appropriate pain medications, as above.
5. Left-sided intercostal rib pain. Felt to be neuralgic in nature. We will obtain rib films to make sure no bony abnormalities. She will continue to follow with Dr. Brandt. Continue her Ultram CR, her Lyrica, and her Lidoderm patch.
6. Abdominal discomfort. Has been persistent but significantly improved since lysis of adhesions. She will follow with Dr. Odom, if needed.
7. Fatigue. Will check all endocrinologic and metabolic markers.
8. Bradycardia. EKG unremarkable. I suspect that this is medication induced, as she is both on a rate controlling calcium channel blocker and beta blocker.
9. Routine health maintenance. Basically up to date. She will need repeat colonoscopy in 2009, as her last was in 2004 and unremarkable. She was strongly encouraged to increase her cardiovascular exercise regimen, which she has done, watch her diet more thoroughly and perhaps lose some weight. We will continue to follow her extremely closely. See routine health maintenance form.


Jeffrey D. Hook, MD

(495)

**MIDLANDS INTERNAL MEDICINE
OFFICE VISIT NOTE**

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/20/06

The patient is a 52-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilatation times two, chronic back and neck pain, left ankle pain, and left chest wall pain felt to be neuralgic in nature, who basically presents for follow-up of her medical problems. The patient suffered a fall in May. She basically injured her right wrist and both of her knees. She basically had no significant findings on x-ray and has been seen ultimately by Dr. Noojin at Moore Orthopedics. He suspects that she still suffers from a left wrist tendonitis and bilateral patellofemoral syndrome on both knees. She has been in physical therapy, is using a wrist splint and braces, but is still having some discomfort. The patient does note that she has apparently lost her job. She claims that she wrote a book about her life's experiences and included some things about her job, which apparently management was not pleased with. She is considering legal counsel in this regards. She also notes that over the last three weeks, she has been having persistent nausea. She denies any vomiting. She denies any abdominal pain. She denies any change in her bowel habits. She denies any hematochezia, melena, etc. She actually has had no vomiting, fever, or chills. She just has the sensation of nausea. She is using her AcipHex. She notes that this does not seem to be working as well as it once was, as she is having some minimal dyspepsia. She denies any true dysphagia. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.
ALLERGIES: Unchanged as previously documented in the chart.
MEDICATIONS: Unchanged as previously documented in the chart.
SOCIAL HISTORY: Unchanged as previously documented in the chart.
FAMILY HISTORY: Unchanged as previously documented in the chart.

REVIEW OF MEDICATIONS:

- ✓1. Cardizem CD 120mg q day (branded)
- ✓2. Tenormin 25mg bid (branded)
- ✓3. Mobic 15mg q day
- ✓4. Baby aspirin q day
- ✓5. Tylenol prn
- ✓6. Skelaxin prn (v.m.)
- ✓7. Ultram CR 100mg q day (bid)
8. AcipHex 20mg q day (changed to Nexium 40mg q day)
9. Maalox prn
- ✓10. Lortab prn
- ✓11. Lyrica 100mg bid prn
- ✓12. Lidoderm, 12 hours on and 12 hours off

(496)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/20/06

PAGE 2 OF 3

REVIEW OF SYSTEMS: The patient is still following with Dr. Brandt of Pain Management. She has a mild peripheral neuropathy, which has been stable on Lyrica. She notes that her blood pressures have been well controlled and she has had only minimal palpitations, which have been short lived and quite rare.

PHYSICAL EXAM: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Regular.

ABDOMEN: Benign.

EXTREMITIES: No edema.

NEUROLOGIC: Nonfocal.

MUSCULOSKELETAL: Some tenderness over the radial aspect of the left wrist, as well as some tenderness along the patellar region of both knees.

ASSESSMENT AND PLAN:

1. Nausea. Unsure of the etiology. We discussed her diet, which has not necessarily changed. She is on no new medications at this point. At this time, as she is having mild breakthrough dyspepsia, we will go ahead and place her on Nexium 40mg q day. If she is not getting relief, we had discussed perhaps a swallowing study to ensure she is not developing any further stricture. We will be following her closely.
2. Paroxysmal supraventricular tachycardia. Stable on current medications.
3. Hypertension. Well controlled.
4. Degenerative disc disease. Continue Mobic 15mg daily.
5. Left-sided intercostal rib pain. Felt to be neuralgic in nature. Continue Lyrica, Ultram CR, and Lidoderm patch.
6. Abdominal discomfort. Again, has not had significant problems since lysis of adhesions. She will follow with Dr. Odom, if needed.

(492)

MIDLANDS INTERNAL MEDICINE

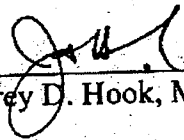
OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/20/06

PAGE 3 OF 3

ASSESSMENT AND PLAN: (cont.)

7. Mild peripheral neuropathy. With negative work-up. Continue Lyrica.
8. Routine health maintenance. Basically up to date. She was given a flu shot.
9. Disposition. Apparently, the patient's wrist and knee pain were felt to be pre-existing conditions from her insurance company. We have written that this accident actually took place in May, when she was seen here three weeks later in June. Our office manager, Debbie, discussed this with her insurance company that she had had no knee and wrist pain prior to this date.



Jeffrey D. Hook, MD

(498)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/27/07

The patient is a 52-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, chronic back and neck pain, left ankle pain, left chest wall pain felt to be neuralgic in nature, and bilateral knee and right wrist pain, who basically presents for complete physical exam. The patient notes all-in-all, she feels as though she is doing well. She continues to have a variety of pain, basically regarding her chronic back and neck pain. Her left ankle pain, fortunately, has somewhat improved, as well as her left chest wall pain. She did fall back in May of 2006 injuring her right wrist and both of her knees. She has followed with Dr. Noojin at Moore Orthopedics and is currently using Mobic for anti-inflammatory effect and Ultram CR for pain control. She has also been on Lyrica as needed for her thoracic neuralgia, which seems to be reasonably well controlled, along with Lidoderm. She does note that she is perhaps more fatigued. However, she does note that she is currently unemployed and is basically living a sedentary lifestyle. Other than that, she has no major complaints and basically feels well.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995
3. Laparoscopic lysis of adhesions by Dr. Odom in 2004

ALLERGIES:

1. Tetanus caused severe edema with localized induration
2. CT dye has given her hives and palpitations.
3. PPD caused hives and palpitations.
4. Questionable sulfa drugs

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day (branded)
2. Tenormin 25mg bid (branded)
3. Mobic 15mg q day
4. Baby aspirin q day
5. Tylenol prn
6. Skelaxin prn (rare)
7. Ultram CR 100mg bid
8. Nexium 40mg q day

(499)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/27/07

PAGE 2 OF 4

CURRENT MEDICATIONS: (cont.)

9. Lyrica 100mg bid prn
10. Lidoderm prn
11. Ultrase, two prior to meals.

SOCIAL HISTORY: The patient is not a smoker, nor does she drink alcohol. She is not married and has no children, and is not sexually active. She is originally from Gadsden and has lived in Charleston but has lived back to Gadsden since 1998. She was a cardiac nurse but became disabled due to back pain. She is currently unemployed. She apparently had to leave Medical Records at Palmetto Richland due to some political issues. She is currently enrolled at ECPI and is taking courses in medical administration. In her free time, she is generally reading but, again, stays quite sedentary.

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90 with diabetes, dementia, which is felt to be multi-infarct. She denies any overwhelming amounts of heart disease in the family but does note hypertension and stroke. She also notes diabetes. There is a history of breast cancer in her family as well as a sister who passed away from colon cancer in her 50's. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet has been fair. Her water intake is reasonable. She denies any caffeine. Her exercise has been extremely poor.

REVIEW OF SYSTEMS: The patient is up to date on eye exam with Dr. Blake. She does have occasional nausea, which she relates perhaps to her medications. She does have Phenergan available, if needed. She really is asymptomatic in regards to her reflux on Nexium, unless she overeats. Again, she has significant pain, somewhat diffusely. She does have a mild peripheral neuropathy but her neurologic work-up was negative. This does not seem to be quite as active as it once was. She notes rare diarrhea. She did have another colonoscopy by Dr. Saleeby, which was completely unremarkable. She does take Ultrase prior to meals, which she claims has helped to some degree. She does note a moderate amount of fatigue. She notes that her periods have begun to fluctuate but she denies any hot flashes. She does note that, at times, she has a mild amount of drainage from her mammoplasty scar on the left but can use Neosporin, which resolves it. She has no other major complaints. All other systems reviewed at this time and negative.

(509)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/27/07

PAGE 3 OF 4

PHYSICAL EXAM: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light and accommodation. Extraocular movements intact. Fundoscopic exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No bruits. No lymphadenopathy. No thyromegaly.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardic. Normal S1 and S2. No murmurs, rubs, or gallops auscultated.

CHEST WALL: Left-sided chest pain, mild in nature. Does appear improved. This is throughout the left-sided chest wall.

BREASTS: No dominant masses. Mild fibrocystic changes. Scar tissue noted from previous mammoplasty. No nipple inversion. No skin dimpling. No axillary nodes.

ABDOMEN: Soft, nondistended, nontender. Positive bowel sounds in all quadrants. No hepatosplenomegaly or mass.

UROGENITAL: Normal external female genitalia. Cervix visualized. Pap smear obtained. Bimanual exam, unremarkable.

RECTAL: Normal sphincter tone. No palpable masses. Guaiac negative stool in the vault.

EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS:

1. EKG was obtained and reveals a normal sinus rhythm. There are no significant ST T-wave abnormalities.
2. Urinalysis was obtained and negative.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
2. Hypertension. Extremely well controlled.
3. Reflux. Continue Nexium with prn Maalox.
4. Diffuse joint complaints. Continue Mobic and Ultram. She has been evaluated by Orthopedics and Pain Management.

(501)

MIDLANDS INTERNAL MEDICINE

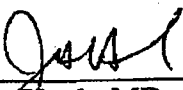
PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/27/07

PAGE 4 OF 4

ASSESSMENT AND PLAN: (cont.)

5. Left-sided intercostal rib pain. Felt to be neuralgic in nature. Continue Ultram, CR, Lyrica, and Lidoderm.
6. Abdominal discomfort. Has somewhat improved. She did undergo lysis of adhesions, which was helpful. She did have recent colonoscopy. She does feel as though the Ultrase has been somewhat helpful.
7. Fatigue. Will check all endocrinologic and metabolic markers.
8. Change in periods. Will check an FSH level.
9. Onychomycosis. The patient defers on Lamisil treatment.
10. Routine health maintenance. Basically up to date. As she had a normal colonoscopy in 2007, she will likely not be due until 2012 and Dr. Saleeby will take over. She is otherwise completely up to date. We have strongly encouraged her to begin a more regimented exercise program, watch her diet more closely, and try to get some of her weight off.



Jeffrey D. Hook, MD

(502)

* Final Report *

Result Type: CR Chest 2 Views PA + Lateral
Result Date: 24 October 2003 2:40
Result Status: Auth (Verified)
Verified By: Bayard MD, Walter J on 24 October 2003 14:37
Encounter info: Richland, ERR-Emergency Room, 10/24/2003 - 10/24/2003

* Final Report *

Reason For Exam
786.50-CHEST PAIN NOS

Impression:
CHEST, TWO VIEWS 10/24/2003

CLINICAL HISTORY: ~~Blunt trauma. The patient complains of chest wall pain.~~

PA and lateral views reveal the lungs to be normally expanded and clear. The cardiomediastinal silhouette is normal. No pleural abnormalities are identified.

IMPRESSION:

NORMAL.

Signature Line

*** Final ***

Read by: Bayard MD, Walter J
Released By: Walter J. Bayard
on: 10/24/2003 14:37

Transcriptionist: SDH
Trans Date/Time: 10/24/2003 14:10
Technologist: Mcfarland, Kelly L, Bouknight, Traci L

Completed Action List:

- * Perform by Wooten, Kelly L on 24 October 2003 2:40
- * Assist by Bouknight, Traci L on 24 October 2003 2:40
- * VERIFY by Bayard MD, Walter J on 24 October 2003 14:37

Printed by: Maslow RN, Debra H
Printed on: 3/9/2006 8:12

Page 1 of 2
(Continued)

(503)

10-23-04
CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

SHIVER, Gertrude
#4559

April 23, 2004 Patient is seen in follow up. Continuing to have significant flaring of low back pain. Has had flare of left sciatica as well.

PMH: I completed Second Injury Fund questionnaire for this patient 12/18/03. Patient does have history of multiple injuries, and is definitely candidate for Second Injury Fund.

Patient has history of several injuries to cervicothoracic spine in April and October 1997, resulting in DRE Category II (per *AMA Guides to the Evaluation of Permanent Impairment, 4th edition*) impairment to cervicothoracic spine (3-5%) on 7/29/98. Patient was assessed additional 3% impairment for aggravation of cervical injuries (per *AMA Guides to the Evaluation of Permanent Impairment, 4th edition*) 8/13/01 for injuries sustained in MVC 11/25/00. No additional impairment assessed for contusion to left shoulder and neck with significant flaring/aggravation of same symptoms relating to 10/24/02 work injury, placed at maximum medical improvement 7/1/03 visit. Patient now notes that she fell in a hotel in August 2003, flaring symptoms. This apparently occurred approximately one month after patient was last seen in office. Flared/injured low back, and patient suffered left sciatica following this injury. Patient given Medrol Dosepak by Dr. Hook, benefit noted, symptoms did not quell completely following this medication. Patient unfortunately was then reinjured on 10/23/04, apparently tripped on phone cord, this injury happening at patient's work at hospital. Dr. Hook is current treating physician for this work injury per patient.

ROS: Patient continues to experience intermittent left sciatica. Sometimes with subjective weakness left leg, occasional giving-out. No bowel or bladder complaints of new onset.

Physical Examination: Reveals no definite focal motor deficits either lower limb, no clonus, negative Homan's, but there is decrement noted to light touch noted over medial and lateral calf on left, and SLR is positive on left at 90 degrees in sitting position, negative on right at 90 degrees sitting. No increase in pain on internal and external rotation at either hip. Marked tenderness noted left greater than right L1-2, through L5-S1 lumbar facets as well as over both S1 joints and sciatic notches.

Impression: 1. Chronic cervicothoracic/shoulder girdle myofascial and facet-generated pain, symptomatic S/P multiple injuries noted above.
2. Chronic multifactorial low back pain with left sciatica, with history of prior stable L4-5 disc protrusion/shallow HNP left paracentral with annular tear, recently symptomatic S/P work-related MVA 10/11/97, flared in MVA 11/25/00 and work-related fall from chair 3/23/02, now re-flared/re-aggravated with falls in August 2003 and apparent work-related fall 10/23/04.

Recommendations/Discussion: Gertrude has symptoms consistent with discogenic pain relating to left sciatica. The findings clinically are consistent with this problem. Would recommend that if these symptoms continue, patient will need to be scheduled for left paracentral L4-5 or L5-S1 translaminar epidural block. Will leave scheduling up to patient, based on how symptoms do over next several weeks. Trial oral anti-inflammatory samples given (COX-II inhibitor) with Skelaxin for muscle spasm. Will follow up on as needed basis for flaring. Patient may also require lumbar facet blocks to maximize benefit, particularly in regard to recent reinjury of lumbar spine with these several falls that have occurred over past 8 months.

Gregory M. Jones, M. D.

GMJ/bjl

(504)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

June 8, 2004 Patient is seen in follow up. Has fortunately gotten significant benefit from lumbar epidural block accomplished 5/13/04. Low back and leg symptoms are much improved since this procedure. Pleased with response. Still experiencing moderate bilateral low back pain from thoracolumbar junction down to upper buttock regions. Here today for consideration for lumbar facet blocks as previously discussed.

Physical Examination: Reveals significant tenderness bilaterally L1-2 through L5-S1 facet joints to varying degrees, most significant over lower four levels, moderate over L1-2 level. Moderate tenderness also noted T11-12 and T12-L1 facets to varying degrees bilaterally. Marked tenderness noted over bilateral SI joints at superior aspects of joints. Only minimal tenderness noted over sciatic notches bilaterally on today's exam.

Lower extremity exam reveals downgoing plantar responses, no clonus, negative SLRs bilaterally at 90 degrees sitting, no focal motor deficits, no focal sensory deficits to light touch, reflexes 2+ and symmetric patellar and Achilles responses. No increase in pain on internal and external rotation at the hips. No palpable step off lumbar spine, no spinous process tenderness. No CVA tenderness to percussion, no scapulohumeral motion deficits or scapular winging.

Impression: 1. Chronic multifactorial low back pain with bilateral left predominant sciatica and bilateral buttock pain, with significant discogenic component (symptomatic L4-5 disc protrusion/shallow HNP left paracentral with annular tear), with history of multiple injuries and flares recently, good response noted to recent epidural block.
2. Chronic multilevel lumbar facet syndrome/sacroiliitis, concurrent with above discogenic lumbar pathology, recently flared with multiple injuries.
3. Chronic cervicothoracic/shoulder girdle/interscapular myofascial/facet-generated pain, symptomatic S/P multiple injuries.

Recommendations/Discussion: Gertrude has always done well with epidurals. This has likely quelled any inflammation relating to symptomatic disc lesion L4-5 level. Patient is still candidate for use of this type of epidural procedure every 3-4 months for severe flares of low back pain with left sciatica particularly.

In interim, for residual pain post-block, or for flares of primarily low back and/or buttock pain, patient is still good candidate for use of lumbar facet/SI joint blocks, and the following are accomplished today for this purpose:

1. Right L2-3, L3-4, L4-5, and L5-S1 lumbar facet blocks, 5 mg methylprednisolone acetate (DepoMedrol), with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% bupivacaine HCl MPF (methylparaben-free) per site, sterile technique, non-fluoroscopic, 25 gauge 3.5" spinal needles used at each site; each site anesthetized locally, after sterile preparation, via instillation of 1.5 cc each 0.5% Marcaine HCl 5 mg/mL (bupivacaine HCl) and 2% Xylocaine (lidocaine HCl 20 mg/mL) using 27 gauge 1 1/4" needle.
2. Right SI joint block, 10 mg Aristospan with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% bupivacaine HCl MPF (methylparaben-free), sterile technique, non-fluoroscopic, 25 gauge 3.5" spinal needle used; site anesthetized locally, after sterile preparation, via instillation of 1.5 cc each 0.5% Marcaine HCl 5 mg/mL (bupivacaine HCl) and 2% Xylocaine (lidocaine HCl 20 mg/mL) using 27 gauge 1 1/4" needle.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Follow up will be accomplished in 2-4 weeks at patient's convenience with driver, can go ahead with treatment of left side at that time (if necessary).

This patient had stabilized regarding her low back symptoms, and then re-flared/aggravated low back symptoms with sciatica, particularly after a work-related fall 10/23/03. Goal here regarding treatment since that injury 10/23/04 is simply to stabilize patient's low back and leg symptoms, get her back to her "baseline" level, and we are nearing that level now fortunately. Basically, once left sided facet injections accomplished, assuming that no further lumbar epidural blocks necessary over next 3-6 months, can assume patient at maximum medical improvement relating to 10/23/04 work-related fall within next 2-4 months. Unlikely that additional impairment rating will need to be assessed for this injury, as no definitive "new" pathology delineated relating specifically to 10/23/03 work injury. Since patient is known to have pre-existent pathology lumbar spine prior to 10/23/03 work-related injury, patient would therefore be candidate for inclusion in South Carolina Second Injury Fund relating to the aggravation of lumbar symptoms following 10/23/03.

Gregory M. Jones, M.D.

GMJ/bjl

(505)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

July 7, 2004 Patient is seen in follow up. Has fortunately noted significant benefit for low back and buttock symptoms on right side from 6/8/04 right lumbar facet/SI joint blocks. Here today for similar treatment opposite side. No change in symptoms otherwise.

Past Surgical History: Patient underwent laparoscopic adhesiolysis with pelviscopy on 6/24/04. Was initially scheduled for ovarian cystectomy, but due to extensive pelvic adhesions to large intestine, could not accomplish latter procedure laparoscopically. Patient is pending further work up in this regard by her gynecologist.

Physical Examination: Reveals most significant tenderness over left L2-3, L3-4, L4-5, and L5-S1 lumbar facet regions. Marked tenderness also noted over left SI joint, again worse at superior aspect of joint. Moderate sacrococcygeal/midline tenderness still present. No treatment accomplished on right side, now using this side as "control."

Impression:

1. Chronic multifactorial low back pain with bilateral left predominant sciatica and bilateral buttock pain, with significant discogenic component (symptomatic L4-5 disc protrusion/shallow HNP left paracentral with annular tear), with history of multiple injuries and flares recently, good response noted to recent epidural block.
2. Chronic multilevel lumbar facet syndrome/sacroiliitis, concurrent with above discogenic lumbar pathology, recently flared with multiple injuries.
3. Chronic cervicothoracic/shoulder girdle/interscapular myofascial/facet-generated pain, symptomatic S/P multiple injuries.

Recommendations/Discussion: I have accomplished the following focal injections today:

1. Left L2-3, L3-4, L4-5, and L5-S1 lumbar facet blocks, 5 mg methylprednisolone acetate (DepoMedrol), with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% bupivacaine HCl MPF (methylparaben-free) per site, sterile technique, non-fluoroscopic, 25 gauge 3.5" spinal needles used at each site; each site anesthetized locally, after sterile preparation, via instillation of 1.5 cc each 0.5% Marcaine HCl 5 mg/mL (bupivacaine HCl) and 2% Xylocaine (lidocaine HCl 20 mg/mL) using 27 gauge 1 1/4" needle.
3. Left SI joint block, 10 mg Aristospan with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% bupivacaine HCl MPF (methylparaben-free), sterile technique, non-fluoroscopic, 25 gauge 3.5" spinal needle used; site anesthetized locally, after sterile preparation, via instillation of 1.5 cc each 0.5% Marcaine HCl 5 mg/mL (bupivacaine HCl) and 2% Xylocaine (lidocaine HCl 20 mg/mL) using 27 gauge 1 1/4" needle.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

~~Patient can now be considered at maximum medical improvement relating to 10/23/04 work-related fall. Patient's impairments have already been addressed in regard to her various/multiple complex low back, buttock, hip, and lower extremity injuries, with multiple injury history noted in past. No additional impairment rating assessed today's date, date of maximum medical improvement, relating to 10/23/03 work injury to lumbar spine, as patient aggravated pre-existent pathology lumbar spine with that work injury, based on current understanding of patient's condition. Patient is felt to be candidate for inclusion in SC Second Injury Fund relating to this aggravation of lumbar symptoms with work injury of 10/23/03.~~

Patient continues to be good candidate for intermittent use lumbar facet/SI joint blocks for flares of back/buttock pain relating to joint-related pain complaints of chronic nature. Patient also is candidate for intermittent use (not to exceed 2-4 in any 12 month time frame) of lumbar facet blocks for flares of discogenic/neurogenic low back and/or leg symptoms. Follow up on

pm basis for flaring.

(506)



Charleston Spine &
Physical Medicine, PA

PATIENT

Gertrude Shiver

BIRTHDATE

5/19/54

CHART NUMBER

4559

MALE

☒ FEMALE

PROGRESS NOTES

DATE

7/7/04 (cont) → L4-5 → L5-S1, lumbar facet blocks (5 arthroscopy) +
 (1) SI jt. block (10 fluro) accomplished today 5 complications;
 pt. placed @ MMI (E no additional impairment assessed as of
 today's date per AMA Guides 5TH) for low back injuries /
 aggravation SIP 10/23/03 work injury (chronic currently) /
 → FIC prn in office 2-4 X weekly for unilateral or bilateral
 lumbar facet / SI jt blocks (10 fluro) prn fluro
 LBP / buttock pain
 → FIC prn in block suite 2-3-4 months (or less) for L5-S1
 LESI (10 fluro) for fluro LBP = sciatica / L5

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE

May 13, 2004 PROCEDURE NOTE

PROCEDURE: 1. Left L5-S1 translaminar lumbar epidural steroid injection.

DIAGNOSIS: 1. Recurrent discogenic low back pain with sciatica.

CLINICAL DATA: Refer to Charleston Spine progress notes for details of prior work up and treatment as well as reasoning behind utilization of block procedure(s) today.

PROCEDURE: Informed consent signed and patient's questions answered prior to procedure; risks, benefits, alternative treatment options, and expected prognosis/efficacy discussed. Risks including, but not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring explained to patient's satisfaction.

Patient is placed prone on fluoroscopy table following IV placement. 2 mg Versed given for relaxation prior to and during procedure per IV. Skin and subcutaneous tissue over left L5-S1 interlaminar space identified and anesthetized using 8 cc 1% Xylocaine and 4 cc 0.5% Marcaine.

18 gauge 3.5" Crawford needle used to enter epidural space using loss of resistance to normal saline technique, confirmed by 2 cc 300 Omnipaque epidurogram on AP and lateral views.

AP and/or lateral epidurogram copies obtained via pulse sequence fluoroscopic imaging, copies available in Charleston Spine chart for review.

After assurance of appropriate needle tip location at level(s) noted above, 100 mg DepoMedrol (methylprednisolone acetate injectable suspension 80 mg/mL) injected with 1cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Sensorcaine HClMPF (methylparaben-free bupivacaine HCl injection 5 mg/mL), along with 1 cc normal saline into epidural space, tolerated well, needle withdrawn, no untoward effects or blood leakage noted.

Sterile bandaging applied at appropriate site(s), patient transferred to recovery room in stable condition.

Gregory M. Jones, M. D.

GMJ/bjl

(508)

RETURN TO WORK OR SCHOOL

Gregory M. Jones, M.D.
Charleston Spine and Physical Medicine, P.A.

1930 Charlie Hall Blvd., Charleston, SC 29414
(843) 402-0111 • 1-800-393-7008 • Fax: (843) 402-9010

Date 5/13/04

This is to certify that

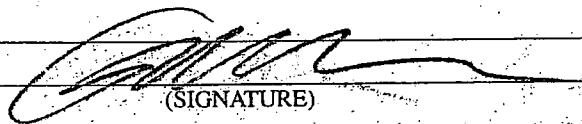
Gertrude Shiver

has been under my care for the following:

CBP, sciatica

and is able to return to work on 5/15/04
school

Remarks: off work today &
tomorrow post-block


(SIGNATURE)

(SIGNATURE)

(SIGNATURE)

(SIGNATURE)
(509)

FEB. 8. 2005 2:05PM

HANDS INTERN MED

NO. 497 P. 2

8/16

ImageCare, LLC-CPG
710 Rabon Rd
Columbia 29203
Phone: (803)462-3680

Name: Gertrude Shiver #71705
Patient ID: 1000021995
DOB: 5/19/1954
Phone: (803)353-3892
Acc#: 42610

Exam Date: 8/17/2004
Exam: Ribs (unilateral)
Reason: 786.50 - PAIN, RIB
Referrer: JEFF HOOK-CPG
2nd Referrer:

Results

DATE EXAM PERFORMED: 8-16-04

HISTORY: Fall.

FINDINGS: AP and oblique views of the left ribs were submitted for interpretation. The left thorax appears to be intact with no evidence of acute fracture.

Steve Glassman, MD

Transcribed By: Dee Dee Martin
Transcribed Date: 8/18/2004
Interpreting Rad: Steve Glassman, MD
Finalized Date: 8/18/2004

Pt. Name: Gertrude Shiver #71705
Patient ID: 1000021995
Exam: Ribs (unilateral)
Acc: 42610

SHIVER, GERTRUDE
0505600363
MR 000521249
05/19/54
50Y F
BRANDT, THOMAS E JR

mult rib films
normal. No old or
acute frx seen. No
other lesions noted.

08/18/04

(dict 8/18)

9-18-04

(510)

Columbia Women's Healthcare, L.L.C.
1301 Taylor Street
Suite 6-J
Columbia, SC 29201

HISTORY AND PHYSICAL

Patient ID: 82546GS

Visit Date: 04/14/2004

Patient Name: GERTRUDE SHIVER

DOB: 05/19/1954

CHIEF COMPLAINT:

Pelvic pain, uterine fibroids, ovarian cysts

HISTORY OF PRESENT ILLNESS:

Gertrude is a 49 year-old single African-American female nulligravida who was seen in the office on 4 / 14 / 04 in consultation with Dr. Jeffrey Hook for pelvic pain and uterine fibroids and ovarian cysts. She recently had an ultrasound that confirmed the presence of uterine fibroids and ovarian cysts. Her last menses was 3 / 24 / 04. Her menses occur every 21 - 22 days lasting 5 - 7 days with moderate flow. She is not sexually active.

PAST MEDICAL HISTORY:

Hypertension, Gerd, palpitations, herniated disk in her lumbar region

REVIEW OF SYSTEMS:

Pelvic pain

ALLERGIES:

Tetanus toxoid, PPD, CAT scan dye

MEDICINES:

Tenormin 25 mg twice daily, Aciphex 25 mg q.d., Cardizem 120 mg q.d., Bextra 20 mg q.d., Phenergan 25 mg p.r.n.

PAST SURGICAL HISTORY:

Myomectomy (6 / 95), bilateral breast reduction (6 / 97)

FAMILY HISTORY:

Mother, brother, sister with diabetes and hypertension; mother and father with a stroke; sister with colon cancer; first cousin with breast cancer

SOCIAL HISTORY:

Does not smoke or drink alcohol

LABS:

Last Pap smear 3 / 29 / 04 and normal according to the patient; last mammogram 2 / 04 and normal according to the patient

PHYSICAL EXAM:

Weight: 194 hemoglobin: 12 blood pressure: 124 / 80 urinalysis: 3 + blood, trace protein

EGBSU: WNL

Vagina: no gross lesions, well rugated

Cervix: parous, grossly normal

Uterus: anteverted, 10-12 weeks size, nontender, mobil

Adnexae: nontender, no masses

Rectal: deferred

(5711)

✓

Patient Name: GERTRUDE SHIV

2 of 2

ULTRASOUND EXAM:

Uterus measures 8.01 x 5.19 x 5.63 cm with endometrial thickness of 6.2 mm; at least 6 uterine fibroids were noted the largest measuring 1.87 x 1.73 cm; there is a resolving a cyst in the right ovary measuring 1.31 x 0.94 cm and a simple cyst in the left ovary measuring 1.02 x 0.79 cm; there is free fluid in the cul-de-sac which appears to be loculated

IMPRESSION:

Minimally enlarged uterus with small bilateral ovarian cyst

PLAN:

I discussed the options with Gertrude today. While a hysterectomy is certainly an option I didn't recommend that strongly to her. At any rate she declined to proceed with that. I recommended she continue taking Bextra. We will follow-up with an ultrasound in 6 weeks to make sure the ovarian cysts have resolved.

Albert E. Odom, Jr., M.D.

(512)

Columbia Women's Healthcare, L.L.C.
1301 Taylor Street
Suite 6-J
Columbia, SC 29201

PROGRESS NOTE

Patient ID: 82546GS

Visit Date: 06/23/2004

Patient Name: GERTRUDE SHIVER

DOB: 05/19/1954

Gertrude was seen in the office on 6 / 23 / 04 for a pre operative exam. She is scheduled to undergo a laparoscopic left ovarian cystectomy on 6 / 24 / 04. She continues to experience pelvic pain. Other than that she has no complaint.

Physical exam: Weight: 186 hemoglobin: 13.4 blood pressure: 112 / 70 urinalysis: unable to avoid

Lungs: clear

Heart: regular rate and rhythm without murmur rubs or gallops

Gertrude and I discussed the surgery in detail today. She understands that the surgery will be scheduled as an outpatient procedure. While I will attempt to remove only the ovarian cyst it is possible that removal of the ovary may be necessary. We discussed the risks of the procedure. She understands there is a risk of infection particularly in the subumbilical incision. We also discussed the risk of excessive blood loss that may require laparotomy to repair. We also discussed the risk of bowel injury that may require a temporary colostomy to repair. She is to perform a Fleet's enema the night prior to the surgery.

She is to call me during her recovery for temperature >100.4 . Also she is to call for abdominal swelling, increasingly severe abdominal pain, and severe nausea and vomiting. She will be followed up in the office in 7-10 days to check her incision(s).



Albert E. Odom, Jr., M.D.

(SL3)

F

Columbia Women's Healthcare, L.L.C.
1301 Taylor Street
Suite 6-J
Columbia, SC 29201

SOAP NOTE

Patient ID: 82546GS

Visit Date: 07/01/2004

Patient Name: GERTRUDE SHIVER

DOB: 05/19/1954

SUBJECTIVE:

Gertrude it was seen in the office on 07 / 1 / 04 for a post operative exam. She underwent a diagnostic laparoscopy on 6 / 24 / 04. Preoperatively a laparoscopic left ovarian cystectomy had been planned. However due to severe adhesions involving the left ovary, tube, and posterior fundus of the uterus and bowel this could not be done. These adhesions were from her previous myomectomy. She continues to experience pain from her incisions. She denies any fever or chills. And she is having normal bowel function.

OBJECTIVE:

Weight: 187 hemoglobin: 12. 4 blood pressure: 104 / 66 urinalysis: negative

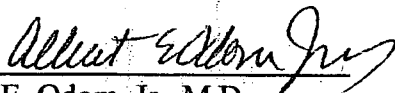
Abdomen: Her incisions appear to be healing well without evidence of infection, the abdomen is soft and not distended

ASSESSMENT:

Normal postoperative exam

PLAN:

Will schedule a follow-up ultrasound in 4 weeks to look at the left ovarian cyst that was present preoperatively.



Albert E. Odom, Jr., M.D.

(514)

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**THE CENTER FOR PAIN MANAGEMENT****PATIENT:** Gertrude Shiver**PHYSICIAN:** Thomas E. Brandt, Jr., D.O.**DATE:** February 4, 2005**MEDICAL RECORD #:** 521249**cc:** CHS, Blanding Street
Jeffrey Hook, M.D.**SHIVER, GERTRUDE**

0503400249

MR 000521249 BRANDT, THOMAS E JR

05/19/54

50Y F



PAIN HISTORY: This 50-year-old right-handed African American female presents with pain in her left chest wall. Onset of pain, October 2003, following a fall injury. She states on 10/23/03, she was working in the Medical Records Department of Palmetto Health Richland when she became entangled in a telephone cord, causing her to fall directly onto a concrete floor, striking the left chest area and both of her hands, while she was trying to break her fall. She states she became very nauseated following the injury, and was initially told to take some ice to help her nausea. She continued to have severe pain and later that afternoon, another supervisor returned, and told her to report to the emergency room. She was seen at Palmetto Health Richland emergency room and underwent x-rays, and was told to follow-up with Dr. Hook, her primary care physician. The patient was treated conservatively with medication, but continued to have a significant amount of pain. The patient underwent a second x-ray, which was also unremarkable, and has not responded well to any conservative measures. The patient describes pain as a constant ache that will increase when the area is palpated. She denies any burning, but she does sting at times, which is an intermittent pain, but denies any numbness. Pain starts under the axilla, radiates around under the breast, and also can cross into the spine. She has been seen by Dr. Gregory M. Jones in Charleston and has undergone apparently cervical facet injections as well as Botox injections for her neck, but her thoracic area has never been treated. The patient has also received attention to the lower lumbar area.

PAIN DESCRIPTION: Musculoskeletal. Neurogenic. The patient does not display any symptoms of dramatization or exaggeration. She denies being nervous, depressed, anxious, or irritable. She does suffer from a sleep disturbance, only sleeping 4-6 hours per night. The patient's appetite and weight are stable. She is not dieting. She has knowledge of pain language. Current VAS score is a 3, best score being a 0, worst score being a 5. **RELIEVING FACTORS:** Pain medications. **AGGRAVATING FACTORS:** Lifting heavy objects will increase her pain.

ONSET OF PAIN: 10/23/03, when involved in a fall injury at work. This is a work-related injury and third party liability is involved.

HABITS: The patient denies use or abuse of alcohol, tobacco, or illicit drugs.

ALLERGIES: PPD; TETANUS, causing tachycardia and itching, while **RADIOPAQUE DYE** caused seizures. The patient does use anticoagulant medication, i.e., aspirin, but denies any easy bruisability.

CURRENT MEDICATIONS: Lortab 5 mg p.r.n., Ultram 50 mg 1-2 q.6h., Bextra 20 mg q.d., Cardizem CD 20 mg q.d., Tenormin 25 mg q.d., Aciphex 20 mg q.a.m., Skelaxin 800 mg p.o. p.r.n., and aspirin 81 mg q.d.

PAST MEDICAL HISTORY: Significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with esophageal stricture, requiring bouginage, i.e., dilatation x 2.

PAST SURGICAL HISTORY: Significant for breast reduction in the past.

(515)

PATIENT:
PHYSICIAN:
DATE:
MEDICAL RECORD #:
Page 2

Gertrude Shiver
Thomas E. Brandt, Jr., D.O.
February 4, 2005
521249

SHIVER, GERTRUDE
0503400249
MR 000521249
05/19/54 50Y F
BRANDT, THOMAS E JR

REVIEW OF SYSTEMS: All systems reviewed. **CONSTITUTIONAL:** Positive for chills. No fevers, history of swollen lymph nodes, or weight loss. **EYES:** No pink or red eyes, history of conjunctivitis, blurred vision, dry eyes, blind spots, or tender scalp. **EARS, NOSE, MOUTH, AND THROAT:** No dry mouth, changes in sense of smell or taste, tinnitus, decreased hearing acuity, epistaxis, sinusitis, sore throat, or hoarseness. **CARDIOVASCULAR:** History of palpitations. No chest pain, shortness of breath, history of orthopnea greater than 1 pillow, paroxysmal nocturnal dyspnea, or diaphoresis. **RESPIRATORY:** No cough, wheeze, shortness of breath, or dyspnea. **GASTROINTESTINAL:** Positive for nausea, vomiting, and diarrhea, as well as constipation. No abdominal burning, loss of appetite, melena, hematochezia, difficulty swallowing, diarrhea lasting longer than two weeks, or history of jaundice. **GENITOURINARY:** No history of pain with urination, urinary frequency, hematuria, swelling in feet and ankles, urinary urgency, or dysuria. **INTEGUMENTARY:** Positive for itching. **NEUROLOGIC:** Positive for syncopal episode in the past. No seizures, convulsions, near syncopal episodes, history of strokes, perceptions of strange tastes or odors, difficulty initiating movement, localized numbness, tingling, or tremor. **ENDOCRINE:** No history of diabetes, high blood sugars, glucose in the urine, thyroid disease, osteoporosis, goiter, history of heat intolerance, or hot flashes. **PSYCHIATRIC:** No history of hallucinations, suicidal ideations or attempts. **HEMATOLOGIC/LYMPHATIC:** No history of anemia, easy bruisability or bleeding, or swollen lymph nodes. **ALLERGIC/IMMUNOLOGIC:** No history of hay fever, recurrent infections, or asthma.

FAMILY HISTORY: Significant for history of colon cancer in her sister; stroke in her father and mother, both now deceased. Hypertension, herself, sister, brothers, and parents. Arthritis in mother and father. Her mother, sister, and brothers all had diabetes mellitus.

SOCIAL PROFILE: This is a 50-year-old African American female, single, with no children.

EDUCATIONAL BACKGROUND: She has a bachelor's degree.

EMPLOYMENT HISTORY: She works as a Medical Director at Palmetto Health Richland. She has had her present job for four years and currently is working.

SOCIAL ACTIVITY: Unsatisfactory. She stays by herself.

SEXUAL ACTIVITY: She is inactive, and that is satisfactory.

MAJOR SUPPORT SYSTEMS: She has no real support systems. She does not talk to her family and will not discuss this issue, nor does she have any friends or consider church a support system. Estimated uptime in a 24 hour period: 12 hours per day. There has been no change in salary since the onset of her pain. **PREVIOUS TREATMENTS:** Include physical therapy. No occupational therapy, behavior medicine, chiropractic, or massage.

SPIRITUALITY: The patient was raised in the Baptist faith, which she continues to practice. She is active. She finds comfort in her faith, and her prayers do help.

PHYSICAL EXAMINATION:

GENERAL APPEARANCE: This is a very pleasant 50-year-old African American female who is in no acute distress. She is alert and oriented x 3.

VITALS: Blood pressure 125/73. Pulse 67. Respirations 20. Height 5 feet 3.5 inches. Weight 200 pounds.

HEAD: Normocephalic, nontraumatic.

NECK: No masses, tenderness, or carotid bruits noted. Trachea midline.

EYES: Pupils equal, round, reactive to light and accommodation. Extraocular muscles are intact. Funduscopic evaluation reveals no hemorrhage or exudates.

EARS: External and auditory canals are bilaterally patent. Tympanic membranes are intact without bulge, retraction, or erythema.

(516)

PATIENT: Gertrude Shiver
PHYSICIAN: Thomas E. Brandt, Jr., D.O.
DATE: February 4, 2005
MEDICAL RECORD #: 521249
Page 3

SHIVER, GERTRUDE
0503400249
MR 000521249 BRANDT, THOMAS E JR
05/19/54 50Y F


PHYSICAL EXAMINATION (cont):

NOSE: No septal deviation noted.

THROAT: Teeth in good repair. Uvula is midline. Posterior pharynx without erythema or exudate.

HEART: Regular without murmur.

LUNGS: Bilaterally clear to auscultation.

ABDOMEN: Soft, bowel sounds are x 4, nontender to palpation.

EXTREMITIES: Present x 4. Peripheral pulses are intact, with the left foot being somewhat cold and shiny in appearance, but, once again, peripheral pulses are intact.

SKIN: No erythemas or ecchymoses noted.

NEUROLOGIC EVALUATION: Deep tendon reflexes are noted to be +2/4 bilaterally with biceps, triceps, brachioradialis, patellar, and Achilles. Babinski is absent. Decreased cutaneous sensation is noted on the left from T7 to L1 with both alcohol wipe and pinprick. No trophic or motor function changes are noted. Muscle strength is assessed and found to be 4-5/5 bilaterally with grip strength, triceps, and biceps, as well as dorsiflexion, plantar extension, quadriceps and hamstrings.

STRAIGHT LEG RAISING: 90 degrees bilaterally, sitting.

MUSCULOSKELETAL REVIEW: Ambulation, slow and antalgic gait, flatfooted gait with slight footdrag. Positive heel and toe walk causing left ankle pain and heel pain. Standing balance is within normal limits. Active and Passive Range of Motion: Cervical spine adequate. Thoracic spine adequate. Lumbar flexion to 90 degrees, extension to 20 degrees. Side bending and rotation adequate. No gross postural or vertebral column defects are noted. No limb defects are noted.

TRIGGER POINTS AND ZONES: Positive tenderness over the left midaxillary line over the rib margins from T6, T7, T8, and T9. No allodynia or hyperalgesia is noted over the chest wall.

OBJECTIVE DATA: Beck's Depression Inventory Score: Noted to be 9/10, indicating no significant depression.

ASSESSMENT/DIAGNOSES:

1. Left chest wall pain, etiology unclear. Intercostal neuralgia versus discogenic process.
2. Multiple somatic complaints. Currently being treated by another physician, i.e., Dr. Jones in Charleston, South Carolina.

The patient made an Emory Classification II, (indicating low pathology/low behavior).

PLAN OF MANAGEMENT:

1. MRI of the thoracic spine.
2. Possible thoracic epidural steroid injection.
3. Possible intercostal nerve blocks.
4. Possible neurosurgical assessment.
5. Will start Gabitril 2 mg 1 p.o. q.h.s. x 10 d., then increase to 4 mg q.h.s. Patient was explained off-label usage.
6. Will consider Arthrotec 75 mg 1 p.o. b.i.d. to be taken with food.
7. Will start Lidoderm patch, apply q.12h. on, q.12h. off, over area of pain.
8. Will assess patient for chest wall pain symptoms. Other pain complaints will be deferred to the other physician in Charleston at this juncture, and narcotic analgesics will be deferred to this physician at this time.
9. Will reassess patient in three to four weeks.

Total face-to-face contact with patient: 59 minutes.

Thomas E. Brandt, Jr., D.O.

TEB/sdm-2/8/05

(512)



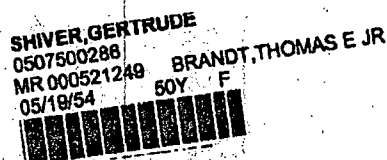
THE CENTER FOR PAIN MANAGEMENT

PATIENT: Gertrude Shiver

PHYSICIAN: Thomas E. Brandt, Jr., D.O.

DATE: March 2, 2005

MEDICAL RECORD #: 521249

cc: CHS, Blanding Street
Jeffrey Hook, M.D.

PAIN HISTORY: The patient presents to the Center for Pain Management today for evaluation and treatment. The patient continues to have pain in her left chest wall. She states that her MRI results are back. She states the Gabitril has helped decrease the burn and actually improve her sleep, but she continues to have throbbing, aching pain in her left chest wall, as well as pain over her left breast area. She states the Lidoderm patch will not stay on during the daytime, as any movement over the chest site will actually cause the patch to detach itself.

PHYSICAL EXAMINATION: Blood pressure 136/84. Pulse 66. Respirations 18. Temperature 98.1 degrees. VAS score is a 6.

HEART: Regular without murmur.

LUNGS: Bilaterally clear to auscultation.

ABDOMEN: Soft, bowel sounds are x 4, nontender to palpation.

NEUROLOGIC EVALUATION: Deep tendon reflexes are noted to be +2/4 bilaterally with biceps, triceps, and brachioradialis, patellar, and Achilles. Muscle strength is assessed and found to be 5/5 with grip strength, triceps, and biceps, as well as dorsiflexion and plantar extension. Positive hyperalgesia is noted over the dorsal rib margins at T4, T5, T6, and T7. No elevated or depressed rib lesions are present. No allodynia or hyperalgesia is noted over the chest wall region.

ASSESSMENT/DIAGNOSIS: Left chest wall pain, etiology unclear. MRI negative for any discogenic disease. Apparent intercostal neuralgic pain state, etiology unclear.

PLAN OF MANAGEMENT:

1. Will schedule intercostal nerve blocks on the left at T3 to T8.
2. Will continue current dosing of Gabitril.
3. Ativan premed has been dispensed.
4. Will consider Yamamoto new scalp acupuncture in the future.

Total face-to-face contact with patient: Slightly over 15 minutes, with greater than 50% of this time spent counseling patient on current pain syndrome, the use of Gabitril, once again, for off-label use of decreasing dysesthesia, which has been very effective for her, as well as improving pre-REM sleep.

Thomas E. Brandt, Jr., D.O.
Thomas E. Brandt, Jr., D.O.
TEB/sdm-3/7/05

(518)

**THE CENTER FOR PAIN MANAGEMENT****PATIENT:** Gertrude Shiver**PHYSICIAN:** Thomas E. Brandt, Jr., D.O.**DATE:** March 21, 2005**MEDICAL RECORD #:** 521249**cc:** CHS, Blanding Street
Jeffrey Hook, M.D.

SHIVER, GERTRUDE
0507500286
MR 000521249 BRANDT, THOMAS E JR
05/19/54 50Y F


PAIN HISTORY: The patient presents to the Center for Pain Management today with continued left chest wall pain secondary to intercostal neuralgia. The patient presents today for scheduled intercostal nerve blocks at the levels of T3, T4, T5, T6, T7, and T8 on the left.

RISK ASSESSMENT: The risks, benefits, and alternatives to intercostal nerve blocks were discussed with the patient at length. She understands and wishes to proceed. Signed informed consent was obtained. Ativan premed dispensed.

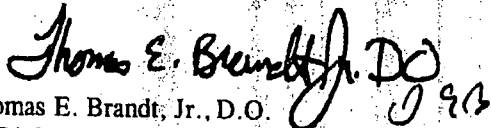
PRE-BLOCK DIAGNOSIS: Left chest wall pain, left intercostal neuralgia at multiple sites.

POST-BLOCK DIAGNOSIS: Same.

ANESTHESIA: None.

PROCEDURE: The patient was taken to the treatment room and placed in a right lateral decubitus position. The rib margins were identified and marked dorsally at T3 to T8 on the left. Using clean technique and ethyl chloride for topical anesthesia, a total of 0.5 ml of 1% lidocaine was injected at each site, following retraction of the skin. Sterile prep and drapes were then applied. Using a #23 gauge 1.5 inch needle placed in a walking-off technique over the intercostal nerves, following negative aspiration for heme, a total of 3 ml of a mixture of 18 ml of 0.25% bupivacaine and 60 mg of methylprednisolone was injected, following negative aspiration every 1 ml. The patient tolerated the procedure well. Pre-block blood pressure 126/80. Pulse 80. Respirations 16. Temperature 98.1 degrees. VAS score was a 5 to a 6. Post-block blood pressure 112/84. Pulse 79. Respirations 16. SpO2 on room air, 97%. Breath sounds were bilateral and equal both pre and post-blockade.

DISPOSITION: Will reassess patient in four weeks.


Thomas E. Brandt, Jr., D.O.
TEB/sdm-3/25/05

**PALMETTO HEALTH
THE CENTER FOR PAIN MANAGEMENT**

NAME: Shiver, Gertrude

RECORD NO: 521249
ACCOUNT #: 0511001927

continued - page 2

DIAGNOSES: Left intercostal neuralgias.

PLAN: Gertrude Shiver is going to continue on her Gabitril prescribed by Dr. Brandt. She was given 4 mg tablets #30 to be taken at bedtime. She was given two refills. She will follow up with Dr. Brandt as soon as his office opens up. Other than that, no changes in her treatment plan at this time. She was told that Dr. Brandt will most likely want a repeat the intercostal nerve blocks when he sees her back in followup, but was informed that I do not perform that type of nerve block.

Timothy Zgleszewski, MD/hs

D: 04/25/2005 11:50 A T: 04/26/2005 11:55 A

Job#: 000303856 HS Job#: «HS_Job_ID» Doc #: 534047

cc:

SHIVER, GERTRUDE

0511001927

MR 000521249 ZGLESZEWSKI, TIMOTHY

05/19/54 50Y F



(520)

**PALMETTO HEALTH
THE CENTER FOR PAIN MANAGEMENT**

NAME: Shiver, Gertrude

RECORD NO: 521249

Date: 4-25-05

ACCOUNT #: 0511001927

CHIEF COMPLAINT: Left chest wall pain.

SHIVER, GERTRUDE
0511001927
MR 000521249 ZGLESZEWSKI, TIMOTHY
05/19/54 50Y F


HISTORY : Gertrude Shiver is a 50-year-old female who is a patient of Dr. Branson being treated for left chest wall pain and left intercostal neuralgia. She is currently on Gabitril by Dr. Brandt and that is doing a fairly good job at controlling her symptomatology. She underwent some recent left intercostal nerve blocks that she said gave her about two weeks worth of significant relief. At this point in time, her pain has returned. It is 5/10 on the pain scale. It is in the left chest wall and lateral thorax. She is reporting no new symptomatology. No new fevers, chills, or drainage from the procedure site since the injection. She also is taking Lortab or Ultram prescribed by Dr. Hook. She reports no other new pain symptomatology. No new side effects from the medicines.

CURRENT MEDICATIONS: As per the New Patient Questionnaire filled out today as well as the history.

ALLERGIES: PPD, TETANUS TOXOID, AND CT DYE.

PAST MEDICAL HISTORY: As per the New Patient Questionnaire filled out today as well as the history.

PAST SURGICAL HISTORY: As per the New Patient Questionnaire filled out today as well as the history.

SOCIAL HISTORY: As per the New Patient Questionnaire filled out today as well as the history.

FAMILY HISTORY: As per the New Patient Questionnaire filled out today as well as the history.

REVIEW OF SYSTEMS: As per the New Patient Questionnaire filled out today as well as the history.

PHYSICAL EXAMINATION: Blood pressure 141/85. Heart rate 80. Respirations 16. VAS is 10 / 10.

GENERAL APPEARANCE: Physical examination reveals a well-developed, well-nourished female in a minimal to moderate amount of discomfort. Grooming, nutrition, and a body habitus are normal for her age. She is alert and oriented to time, place, and person with normal mood and affect.

Gait and station are not antalgic. Inspection of the left thorax reveals a well-healed thoracotomy incision. There are no skin lesions present. No signs of infection from prior procedure site.

Neurologic examination of the upper extremities is intact, including motor strength and sensation.

DIAGNOSTIC TESTING: Medical records from Dr. Brandt are reviewed today.

An MRI of the thoracic spine demonstrates mild degenerative changes at T11-12 and T10-11, T3-4. There is no significant disk herniations or protrusions.

223 STONERIDGE DRIVE COLUMBIA, SC 29210 PHONE 296-5990
FAX 296-2400 www.PalmettoHealth.com

(501)

PROGRESS NOTE

DATE:

11-15-05

PATIENT NAME:

Gertrude Shiver

MIRN:

M 443

Pt presents today for eval/tx. Pt has not been seen by me since 3/31/05 at which time she underwent intercostal nerve block of C2 chestwell pain during to intercostal neuralgia. Pt now is having burning pain in her C2 ankle: foot which is ongoing for several yrs. Pt is being actually tenderly treated at Muller Orthopedic. Pt still on Gabapent. But makes her sleep.

PE. 22 Ozs ms 92.5/50

PE

Head Reg 5 (10)

Long COL TA

Any soft boxy nontender to palpation
 Assessment / Rx
 - T7 - no hyperreflexia

Assessment / Rx

→ ① Chest wall Pain Intercostal Neuralgia

Plan

- Return Intercostal Nerve Block (L) T3-T8
- EMO (lower extremity)
- Start Lipocort 75x 2x per day T 15 days Bed
- Continue night time Gabapentin
- Paracetamol S.C.N.B
- ATWMS Admin
- Possible analgesia
- Reverses sub post Blockage,

2 RL 11/15/05
(522)

PROGRESS NOTE

DATE:

12-8-05

PATIENT NAME: Gertrude Shiver

MRN: M443

The patient presents today for scheduled intercostal nerve blocks at the levels of T3 - T8 on the left.

Risk Assessment:

The risks, benefits and alternative to intercostal nerve blocks were discussed with the patient at length. They state they understand and wish to proceed. (+) signed informed consent was obtained. (+) atium premed dispensed.

Pre Block Dx: chestwall Pain Intercostal neuralgia

Post Block Dx: SAME

Anesthesia: none -

Procedure

Pt taken to treatment room placed in a right lateral decubitus position. Monitors were applied continuous pulse oximetry heart rate monitoring and intermittent Noninvasive Blood Pressure Monitoring q 5 minutes. The intercostal margins of T3 T4 T5 T6 T7 T8 were identified and marked on the left. A total of 1/2 ml of 1% lidocaine was injected over each site. Sterile prep and drapes were applied. Using 23 g 1 1/2 inch needle placed after retracting the skin cephalad and using a walking off the rib technique, following negative aspiration for hema a total of 3ml of a mixture of 19 ml 0.25% Bupivacaine and 80 mg of methyl prednisone was injected at each site following aspiration of 1ml. Pt tolerated procedure well. BS(B) =

Pre Block vital 123/67 70 16 SpO2 99% VAS(8) Temp 97.9

Post Block vital 106/73 70 16 SpO2 99% VAS(6)

Disposition: Ambulatory (+) Order (Mocet) Reopen 3 Yalc
(523) 12/8/05

PROGRESS NOTE

DATE:

1-12-00

PATIENT NAME:

Gertrude Shiver

MRN:

443

(+) (+) ribs improved but still burnt
 (B) feet burnt (1) > (2).

H Res 5/11 2 0, 22 MS 5/15 (B) 9L
 L (B) C-7 2 2 + 1/2 C-1 hypoplasia on (1) lower
 A 8/11/00 2 2 (+) dead tendons

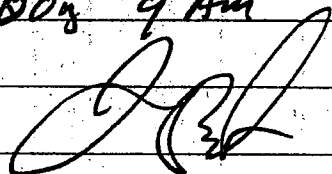
T4 T5 T6. Rib. Marginal Dorsal
 (+) & sensory for ankle down (1)

EMG (+) peripheral Poly
 neuropathy - IgG positive
 ASK 1) Max Rx

- (D) chest wall intercostal neuralgia
- Lower extremity severe peripheral Poly neuropathy status
unclear
- Lyrica helps but makes her sleepy

Plan

- Return Repeat Intercostal NB (1) T3 T4 T5 T6 T7
- Pass Max SCANB (B) (1) (1st)
- Neuropathy working FBS, TSH Free T4 Vit B12 folate RPP
SPRT
- Pass Anecdotal
- ATTENTION premed
- 9 Lyrica 150mg q Am 300mg q b.

 1/12/00

(574)

PROGRESS NOTE

DATE:

2/16/06

PATIENT NAME:

Gertrude Shiver

MRN:

11443

The patient presents today for scheduled intercostal nerve blocks at the levels of T3 T4 T5 T6 T7 on the left.

Risk Assessment:

The risks, benefits and alternative to intercostal nerve blocks were discussed with the patient at length. They state they understand and wish to proceed. (+) signed informed consent was obtained. (+) ativan premed dispensed.

Pre Block Dx: Left Chest wall Pain, Intercostal Neuralgia

Post Block Dx: SAME

Medication: NONE

Procedure

Pt taken to treatment room placed in a right lateral decubitus position. Monitors were applied continuous pulse oximetry heart rate monitoring and intermittent Noninvasive Blood Pressure Monitoring q 5 minutes. The intercostal margins of T3 T4 T5 T6 T7 were identified and marked on the left. A total of 1/2 ml of 1% lidocaine was injected over each site. Sterile prep and drapes were applied. Using 23 g 1 1/2 inch needle placed after retracting the skin cephalad and using a walking off the rib technique, following negative aspiration for hema a total of 3ml of a mixture of 1/2 ml 0.25% Bupivacaine and 80 mg of methyl prednisone was injected at each site following (-) aspiration q 1ml. Pt tolerated procedure well BS(B) =

Pre Block vital 109/71 68 18 SpO2 94% VAS 4

Post Block vital 110/66 62 18 SpO2 98% VAS 1 1/2

Disposition: Ambulatory (+) Driver reassessed B & W

(525) - 11/11 2/16/06

PROGRESS NOTE

DATE:

5-9-06

PATIENT NAME:

Gertrude Shiver

MRN:

443

Pt presents today for eval / tx. Pt reports she is having pain in her (L) anterior chest wall as well as burning pain in her (L) ankle. Pt unable to tolerate Lyrica at 150mg Bid due to "makes me too sleepy". Pt report that the chest wall pain has overshadow her foot until recently as her pain has decrease follow the intercostal Nerve Blocks.

PE

Ht 68 66 16 97⁸ 1-2 (5 activity)

Heart Reg 5 (C)

Lung (C) CTA

ABG Soft BS x 4 non tender to palpation

MS 5/5 9L (C)

- 8/10 cutaneous

- sensation (L) ankle down to toes (stocking) & hyperalgesia

(C) focal tenderness

Assessment / Dx

Chestwall Pain (Anterior) (C) Costochondritis
 improved Intercostal Nerve
 (L) lower extremity pain
 Peripheral Polyneuropathy (Idiopathic) amblyopia or dally.
 - Lyrica dosing causing hypersomnolence

Plan

1 Return Costochondral Injection @ T5 T6 T7

1 Possible Mod Sca/B (L) lower extremity

1 ↓ Lyrica 100mg Bid

1 PT eval / tx Anodyne Tx

1 ATIVION premed

1 Reassess 2-3wk Post Block

(526)

PROGRESS NOTE

DATE:

3/22/06

PATIENT NAME:

Gertrude Shiver

MRN:

443

Patient presents today for scheduled Left costochondral joint injections at the levels of T5 T6 T7 T8 on Left.

Risk Assessment: The risks benefits and alternatives to costochondral injections were discussed with the patient at length. Pt states they understand and wish to proceed. Positive signed informed consent was obtained.
() Arterial prep work was taken.

Pre Block Diagnoses: Anterior chest wall pain, costochondritis

Post Block Diagnoses:

same

Anesthesia:

none

Procedure:

Pt taken to treatment room placed in a supine position on treatment table. Monitors applied continuous pulse oximetry and heart rate monitoring as well as NIBP q 5 minutes. The costochondral joints on the left were identified and marked at T5 T6 T7 T8. Using clean technique and ethyl chloride for topical anesthesia a 30g 1/2" needle was placed at each site following C1 Aspiration for Heme at Total of 3/4 ml of a mixture of 2 ml 0.25% Bupivacaine + 40 mg methylprednisone was injected into each site without complication. Pt tolerated procedure well. Pre Post B&B's
Pre Block vitals 111/65 70 116 97% SpO2 VAS (2) Block
Post Block Vitals 107/64 63 116 99% SpO2 VAS (1-2)

Disposition: Ambulatory, or drive Home 34 hrs

(521)

PROGRESS NOTE

DATE: 4-13-06

PATIENT NAME: Gertrude Shiner

MRN: 443

Pt presents today for eval Ltx. Pt states costochondral injection helped (L) chestwall pain but now pain has moved into her breastbone region under (L) breast and radiates around to her back. Pt states that her pain is at times severe, Pt states that the injections have helped but once again pain has moved. Wky & within per day
PE

123/72 70 16 97⁸ (1-5) O₂ 22 MS 9/5 SL5

Heart Reg (inc)

 $\frac{22}{2} + \frac{1}{2}$

(+) tenderness

Lung (B) CTA

 $\frac{3}{2} / \frac{2}{2}$

+/- hyperaesthesia

ABO soft BS +/- nontender to palpation

over scar line under (L) breast (Breast reduction)

Assessment (dx)

(L) chestwall

No Allodynia or

- Nervous Pain (Surgical Scar) somatic dysfunction

tenderness over (L) costochondral

Junction T4-T10

(+) Elevated T5 Rib on (L)

PLAN- Return B⁴ tabs

- Start Ultram ER 100mg i po q day #101 + 30 pills

- Possible Myofascial Trigger Point Injection

- Consider Acupuncture

- Urine Screen

- Use Lidocaine on scar line

- LFT Blood (hepatome)

- Refers to PT 1-2 x wk & 4 wk

JJS

(578)

PROGRESS NOTE

DATE:

5-11-06

PATIENT NAME:

Gertrude Shiver

MRN:

443

Pt reports today for eval LTx. Pt states that the pain in her ribs on the back are greatly improved but she is having pain in the front of her chest that can go straight through to her back. Pt states that Ultram ER works but only lasts ~12° so her pain is breaking through at times. Pt states she has been on Motrin but it does not seem to help when her pain breaks through her Ultram ER.

PE

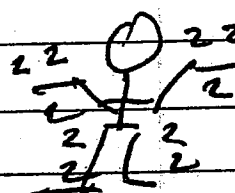
Any preoperative chest (C)

116/75 73 16 98² 1-3 (1) chest (3) @ ankle

Heart Reg (PM)

Lungs C/D/A

ABN SFT BSEY new tender to palpation.



MS 7 & 5/5

(+) focal tenderness

over costochondral junctions T3 T4 T5 (6/10)

Assessment

as (1) mildly tender as (R)

Chest wall Pain

Costochondritis T3 T4 T5 (C) (R) rib tenderness dorsolaterally

Intracostal neuralgia resolved & injected

Ultram ER work but only last 12°

PLAN

- 1) costochondral Injection (L) T3 T4 T5
- 2) 7 Ultram ER 100mg q 12° #60
- 3) Ultram 50mg q 12° to 98° pain episode per #30 Rx full
- 4) Consider Celebrex to replace Motrin or Advil.

(30) 1/12/1

PROGRESS NOTE

DATE:

6-8-06 ?

PATIENT NAME:

MRN:

Patient presents today for scheduled left costochondral joint injections at the level of T3 T4 T5

Risk Assessment: The risks benefits and alternatives to costochondral injections were discussed with the patient at length. Pt states they understand and wish to proceed. Positive signed informed consent was obtained (+) Arterial premed was taken.

Pre Block Diagnosis: Anterior chest wall pain, Costochondritis

Post Block Diagnosis:

same

Anesthesia:

none

Procedure:

Pt taken to treatment room placed in a supine position on treatment table. Monitors applied continuous pulse oximetry and heart rate monitoring as well as NIBP q 5 minutes. The costochondral joints on the left were identified and marked at T3 T4 T5. Using clean technique and ethyl-chloride for topical anesthesia a 30g 1/2" needle was placed at each site following E1 Aspiration for Heme at Total of 30 ml of a mixture of 20 ml 0.25% Bupivacaine + 90 mg methylprednisone was injected into each site without complication. Pt tolerated procedure well Pre Post BSBZ

Pre Block vitals 97/55 64 16 97% 1 1/2-2

Post Block Vitals 100/66 72 16 98% 3

Disposition: Ambulatory, (+) Driver reassess 3 wks
(530) / In s/h

PROGRESS NOTE

DATE:

1-13-06

PATIENT NAME:

Gertrude Shiver

MRN:

443

Pt reports today for eval. Hx. Pt states that the costochondral injection did help a great deal. Now pain is more intermittent and current she is 3 pain. The pain when it does occur is a stinging burning pain. Pt states Day time Lyrica still makes her sleepy. ↑ Lyrica at Hs makes it difficult to wake up the next day.

PR 117/71 72 10 77°

Heart Reg 5 (M)

Long (B) CTA

ABD 3/4 Bx4 needle to palpation

22 0 2 2

MS 9-5/5

st. tenderness over

paraspinal muscles
in C2-T6.

3-5 pain

Assessment / Dx

Chestwall Pain / Costochondritis
Intercostal Neuralgia

no hyperalgesia or
allodynia over intercostal
chestwall T2-T10 or

chronic spas thoracic paraspinal
muscles

Distal small joints

no costochondral joint tenderness

(B).

PLAN

1) Hold Daytime Dose Lyrica (too sedating), Continue night time dose

2) Start Tizanidine 2mg 2x per day then

3) Start Zanaflex 8mg 2x per day for spas

4) Refill Valium 10mg BID

5) Post 5/6 TPI

6) Continue Lidocaine

7) Possible Botox

8) Reassess 3-4 wk

(S3U)

(182)

OGRESS NOTE

DATE:

8-15-06

(8-10-06?)

TIENT NAME:

Gertrude Shiver

MRN:

443

Pt presents today for eval ltx. Pt states overall she is doing well. she has some chest pain but overall she is doing very well. Pt is tolerating Lypira at night.

PE 113/67 70 16 97.5 SPO₂ 99% VAS ✓

Heart Reg (W)

Lung (B) TA

ABD Soft Bxxy nontender to palpation

MS 92.5/5 (B)

① Mild tenderness over

② Rib Margins Dorsal/laterally at T₆ - T₈.

mild costochondral tenderness

T₆ T₇ T₈ (B)

Assessment (D)

chestwall Pain

Costochondritis

Intercostal Neuralgia

no hyperalgesia over dorsal/persistent region.

} stable

PKA

- Continue current Med

- Possible great Costochondral Junction tenderness

- Possible Acupuncture (YNSA)

- Reassess 2 wks

[Signature]

(532)

PROGRESS NOTE

DATE:

10-5-06

PATIENT NAME:

Gertrude Shiver

MRN:

443

Pt presents today for eval / tx. Pt states that she has very little chestwall pain. but she has pain over right knee following a fall injury. recently. She is seeing an orthopedic surgeon. She is able to tolerate her Lyrica 100mg at night and she continue to use her Ultram ER twice a day.

PE

107/58 66 16 97/9 (1-1 1/2)

Heart R 3 (M)

Lung (B) CTA

ABD Soft Bx Nontender to palpation.

22 0 22 MS 7.1 5/5 (B)

2 2 2 2

- no hyperalgesia

or allodynia over the

sternal or peristernal region

bilaterally or over the dorsal

Ribs Bilaterally Mild Erector

spinal spasm (B) T3 - T9

R (R4) leg in knee immobilizer

no costochondral junction

tenderness (B) T3 - T8

Assessment / Dx

Chestwall Pain

Intercostal Neuralgia

Costochondritis

(R) knee pain

being currently tx by orthopedic surgeon (Dr. Neight)

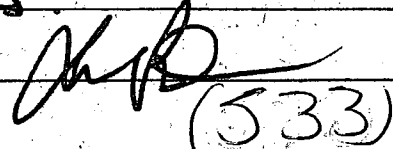
Plan

1) Continue Ultram ER #60 i po bid

2) continue Lyrica 100mg i po qd

3) will address knee pain if not controlled by orthopedic intervention

4) Reassess discomfort



(533)

PHYSICIAN NOTE

DATE:

12-5-06

PATIENT NAME:

Gertrude Shiver

MRN:

443

Pt presents today for eval & tx. Pt states she has minimal chest wall but major of pain is left sided. She is using lidoderm 2 patches q 12° on q 12° off but really could use more coverage at time.

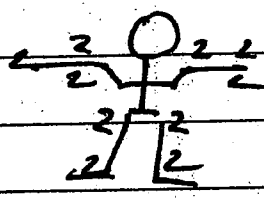
PE

129/83 69 16 92° (1½)

Heart Reg 5 (u)

Lung (S) CTA

ABD Soft 6x4 ant tender to palpation



MS T4 T5

+ mild costochondral

junction tenderness

on (L) T4 T5 T6

no intercostal muscle

tenderness T3 - T12

no dorsal chest wall tenderness on (L).

Assessment / DX

- (L) chest wall Pain

- Costochondritis

Intercostal Neuralgia stable

Plan

1) Increase lidoderm to 3 patches q 12° on q 12° off

2) Continue current med

3) Possible costochondral junction injections

4) Re-eval 2 months or PRN increased pain

(534)

DATE: 2-8-07

PATIENT NAME: Gertrude Shiver

MRN: 443

pt presents today for eval / tx. Pt states her (L) chestwall pain is stable. She does not really have any significant chestwall pain. She uses her medication intermittently and still has medication left for 10/06.

PE

134/84 68 16 97° (1)

Heart Reg 5 (1)

Lungs (3) PTA

NOV soft Bx & tenderness to palpation

$$\begin{array}{c} \sim \sim \sim \sim \sim \\ \sim \sim \sim \sim \sim \\ \sim \sim \sim \sim \sim \end{array}$$

MS 125/5

(L) chestwall

tenderness to palpation.

(L) Intercostal space noted

(L) Costochondral junction

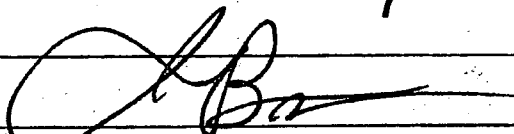
tenderness on (L) T3-T8

Assessment / Dx

(L) chestwall pain
Intercostal Neuralgia } stable
costochondritis }

Plan

- 1) Continue medication per
- 2) avoid situations that would stretch chestwall
- 3) Reassess pt on PRN basis
- 4) Counsel pt on not waiting to see until pain severe


(535)

**EMG/NERVE CONDUCTION STUDY
PHYSICAL MEDICINE & REHABILITATION CONSULTATION**

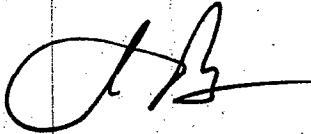
PATIENT: Gertrude Shiver

DATE OF EVALUATION: 11/28/05

REFERRING PHYSICIAN: Dr. Brandt

IDENTIFICATION: Gertrude Shiver is a 48 year old female referred to my office to evaluate left lower extremity dysesthesias and paresthesia.

IMPRESSION:

- 
1. This is an abnormal electrical study.
 2. There is evidence of fairly diffuse slowing motor and sensory nerves of the lower extremities distally consistent with a peripheral polyneuropathy.
 3. No evidence of other nerve conduction abnormalities.
 4. No evidence of radiculopathy on needle exam although there was axonopathy of the foot intrinsic musculature again consistent with peripheral neuropathy.

NERVE CONDUCTION STUDY:

NERVE	DISTAL LATENCY	AMPLITUDE	NERVE CONDUCTION VELOCITY
Right peroneal motor nerve	8 ms (normal is less than 6)	.667 mv	In the leg 45 m/s (normal is greater than 40)
Left peroneal motor nerve	5.4 ms	3 mv	41 m/s
Right tibial motor nerve	7 ms	10 mv	40 m/s
Left tibial motor nerve	7.9 ms	9 mv	40 ms
Right superficial peroneal sensory nerve over 12 cms.	4.2 ms (normal is less than 3.8)	14 mcv	
Left superficial peroneal sensory nerve	4.2 ms	30 mcv	
Right sural sensory nerve	2.7 ms (normal is less than 2.5)	16 mcv	
Left sural sensory nerve	2.9 ms	22 mcv	

ELECTROMYOGRAM: Electromyography was performed with a sterile disposable monopolar needle. The following muscles were checked.

(536)

EMG/NERVE CONDUCTION STUDY **PHYSICAL MEDICINE & REHABILITATION CONSULTATION** **PAGE 2**

PATIENT: Gertrude Shiver

Muscles	IA	Rest					Minimal Contraction MUAP	Maximum Contraction Recruitment Pattern
		Muscle	Spontaneous Activities					
			FIBS	SW	FASC	Other		
Left anterior tibialis	Normal	Normal	None	None	None	None	Normal motor unit morphology and normal motor unit recruitment	Full interference pattern noted
Left peroneus longus	Normal	Normal	None	None	None	None	Normal motor unit morphology and normal motor unit recruitment	Full interference pattern noted
Left medial gastroc	Normal	Normal	None	None	None	None	Normal motor unit morphology and normal motor unit recruitment	Full interference pattern noted
Left vastus medialis	Normal	Normal	None	None	None	None	Normal motor unit morphology and normal motor unit recruitment	Full interference pattern noted
Left extensor digitorum brevis	Normal	Normal	None	None	None	None	Occasional polyphasic motor units seen, slightly reduced recruitment frequency.	Slightly reduced interference pattern was noted.
Left first dorsal interosseous	Increased	Abnormal	None	1+	None	None	Reduced recruitment frequency.	Reduced interference pattern was noted.

HISTORY OF PRESENT ILLNESS: Gertrude Shiver relates left lower extremity trauma in the past and for over a year she has pain and decreased feeling outside of her foot. She does have back pain and known herniated disk but does not feel these two are related. She has been seeing Dr. Brandt for some flank pain but also noted to have these findings and was sent for EMG for further diagnostics.

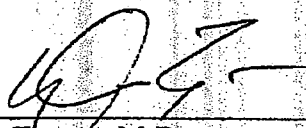
(532)

EMG/NERVE CONDUCTION STUDY
PHYSICAL MEDICINE & REHABILITATION CONSULTATION
PAGE 3

PATIENT: Gertrude Shiver

PHYSICAL EXAMINATION: Very pleasant, cooperative, awake, alert female. Her foot intrinsic musculature is weak bilaterally. Extensor digitorum was in the 4- out of 5 range. Extensor hallucis 4- out of 5. Ankle dorsiflexors 4 to 4+ out of 5 and a little bit stronger. More proximal strength in the 4+ out of 5 range. Reflexes were 2+ out of 4 at the ankles and knees.

DISCUSSION: I discussed the abnormal electrical findings today with Ms. Shiver and recommended followup with Dr. Brandt for further treatment or eval. It is a pleasure seeing her today. Call me if you have any questions.



Devin Troyer, M.D.
Physical Medicine & Rehabilitation

DT/prs

D: 11/28/05

T: 11/28/05

cc: Dr. Brandt
Dr. Troyer

(538)

FEB-16-2005 WED 10:15 AM PALMETTO IMAGING

FAX NO. 803 256 6302

P. 02



Palmetto Imaging

THE CENTER AT LADY & MARION

PATIENT: Shiver, Gertrude
MRN: 348937
DATE OF BIRTH: 5/19/1954
REF PHYSICIAN: Thomas Brandt, MD
DATE OF EXAM: 2/15/2005
PATIENT PH#: 803-353-3892

MRI OF THE THORACIC SPINE

HISTORY: Left rib and breast area pain.

TECHNIQUE: The following sequences were obtained using a Siemens 0.2 Tesla open viva: Sagittal T1, sagittal proton density and T2, and axial T1.

FINDINGS: The vertebral bodies are of normal height and position. The marrow signal of the visualized vertebral bodies appears normal. The thoracic cord appears normal. Specifically, there is no evidence of cord compression, injury, or gliosis.

There is a small anterior osteophyte seen at T11-12. There is disc desiccation at T10-11 and T3-4. There is no significant posterior disc bulge. No focal disc herniations are seen. No soft tissue paraspinal masses are seen.

CONCLUSION:

1. Mild degenerative disc disease.

Robin Daum-Kowalski, MD
Radiologist

RD/bl

This document has been electronically reviewed and signed.

SHIVER, GERTRUDE
0505600363
MR 000521249 BRANDT, THOMAS E JR
05/19/54 50Y F



(539)

FEB. 8. 2005 2:05PM

LANDS INTERN MED

12 3 p.m.

11-10-2005

11/12

NO. 497

P. 2

ImageCare, LLC-CPG
710 Rabon Rd
Columbia 29203
Phone: (803)462-3680

Name: Gertrude Shiver #71705
Patient ID: 1000021995
DOB: 5/19/1954
Phone: (803)353-3892
Acc#: 42610

Exam Date: 8/17/2004
Exam: Ribs (unilateral)
Reason: 786.50 - PAIN, RIB
Referrer: JEFF HOOK-CPG
2nd Referrer:

Results

DATE EXAM PERFORMED: 8-16-04

HISTORY: Fall

FINDINGS: AP and oblique views of the left ribs were submitted for interpretation. The left thorax appears to be intact with no evidence of acute fracture.

Steve Glassman, MD

Transcribed By: Dee Dee Martin
Transcribed Date: 8/18/2004
Interpreting Rad: Steve Glassman, MD
Finalized Date: 8/18/2004

Pt. Name: Gertrude Shiver #71705
Patient ID: 1000021995
Exam: Ribs (unilateral)
Acc: 42610

SHIVER, GERTRUDE
0505600363
MR 000521249
05/18/54
F
BRANDT, THOMAS E JR

only rib films
normal. No old or
acute frx seen. No
other lesions noted

08/18/04

(dict 8/18)

8-18-04

(540)

Bruce D. Filler, M.Ed., P.T.
Director



Columbia
Rehabilitation
Clinic, Inc.

2362 Two Notch Rd.
Columbia, SC 29204
799-7007 - Fax 256-8410

3000 Northeast Medical Park
Columbia, SC 29223
736-4845 - Fax 736-8674

4350 St. Andrews Rd.
Columbia, SC 29210
772-2735 - Fax 798-5514

1177 Sunset Blvd
W. Columbia, SC 29169
794-3440 - Fax 791-3862

PHYSICAL THERAPY PROGRESS UPDATE

PATIENT: Hertude Shiven DATE: April 10, 2006
DIAGNOSIS: Peripheral Neuropathy PHYSICIAN: Dr. Branch

I. TREATMENT INFORMATION

A. Date of Evaluation 3-14-06 Last Summary _____
B. Number of Treatments to Date 12 Cancellations _____ No Shows _____
C. Treatment Techniques Balance / proprioception ex.
D. Modalities Aradyne
E. Home Program _____

II. SUBJECTIVE INFORMATION

A. Pain Intensity (0-10) Initial eval. pt. rated pain a "7". Today
B. Symptoms pt. rates pain a "4 1/2". Today pt. c/o heel pain &
tingling in 1st foot.

III. OBJECTIVE INFORMATION

A. ROM _____
B. MMT _____
C. Girth _____
D. Sensation Pt. didn't exhibit any ↓ed sensation & microfilament
E. Observation/Palpation test.
F. Other _____

IV. ASSESSMENT

Pt. balance improving. Subjectively, pt. is reporting
less pain. If you feel pt. could benefit from
2 more sessions, please advise. Thank you so much for
this referral.

V. RECOMMENDATIONS / PLAN

A. Request to Continue P.T. _____
(To Continue P.T. complete script on right and return)

B. Discharge from P.T. _____
Reasons for D/C _____

Chris Rieger
Physical Therapist

PRESCRIPTION

Total Visits: 2 x / week 4 weeks
Continue P.T. ☒
Area to be treated: _____
Any Changes: _____
Contraindications: _____

Dr. Branch
MD

4/13/06
Date

Bruce D. Filler, M.Ed., P.T.
Director



Columbia
Rehabilitation
Clinic, Inc.

DOB 5-17-57

SSN 249-98-2541

* Pt has apt today

2362 Two Notch Rd.
Columbia, SC 29204
799-7007 · Fax 256-8411

3000 Northeast Medical Park
Columbia, SC 29223
736-4845 · Fax 736-8674

4350 St. Andrews Rd.
Columbia, SC 29210
772-2735 · Fax 798-5514

1177 Sunset Blvd
W. Columbia, SC 29169
794-3440 · Fax 791-3862

PHYSICAL THERAPY PROGRESS UPDATE

PATIENT: Gertrude Shiver DATE: 5-10-06

DIAGNOSIS: Peripheral Neuropathy PHYSICIAN: Brandt

I. TREATMENT INFORMATION

A. Date of Evaluation 3-14-06 Last Summary _____
B. Number of Treatments to Date _____ Cancellations _____ No Shows _____
C. Treatment Techniques Balance, Proprioception, LE strengthening
D. Modalities Anodyne
E. Home Program _____

II. SUBJECTIVE INFORMATION

A. Pain Intensity (0-10) Pt reported pain varies. 7/10 initially has been
B. Symptoms as low as 4/10. (L) > (R)

III. OBJECTIVE INFORMATION

A. ROM _____
B. MMT _____
C. Girth _____
D. Sensation _____
E. Observation/Palpation Pt c no exhibit of ↓ d sensation c microfilament test
F. Other _____

IV. ASSESSMENT

Pt c improved reported balance. Have added some LE strengthening
exs for pt to be doing at home & pt has returned to ymca to
get back into cardio program that she was doing prior to LE problems.
Please re-eval & advise. Thank you for this referral.

V. RECOMMENDATIONS / PLAN

A. Request to Continue P.T. _____

(To Continue P.T. complete script on right and return)

B. Discharge from P.T. _____

Reasons for D/C _____

Kim Newman P.T.
Physical Therapist

PRESCRIPTION

Total Visits: _____ x / week _____ weeks

Continue P.T. _____

Area to be treated: _____

Any Changes: _____

Contraindications: _____

MD

Date

(542)

**PALMETTO RICHLAND REHABILITATIVE CARE CENTER
PHYSICAL THERAPY**

PROGRESS / RE-EVALUATION REPORT

Patient Name: GERTRUDE SHIVER

Date: 1-25-02

Physician: DR MARTIN DURKIN

Diagnosis: LEFT FOOT PAIN

Therapy Attendance: from: 12-27-01

to: 1-25-02 sessions treated: 12 sessions missed: 0

MODALITIES / PROCEDURES USED:

- | | | | |
|--|---|---|---|
| ☒ Strengthening | ☐ Massage | ☐ Ultrasound | ☐ TENS |
| ☐ Aquatic Therapy | ☐ Soft Tissue Mobilization | ☒ Hot/Cold therapy | ☒ Iontophoresis |
| ☒ ROM/Stretching | ☐ Joint Mobilization | ☐ Electrical Stimulation | ☐ Paraffin |
| ☐ Work Conditioning | ☐ Manual techniques | ☐ Traction | ☒ Home Program |
| ☐ Trunk Stabilization | ☐ Lifting Mechanics | ☒ Patient instruction | ☐ |

Status: 0 - NO PROGRESS 1- SLOW PROGRESS 2- GOOD PROGRESS 3- GOAL MET
1 Decreased pain (on numeric pain scale of 0 to 10, patient rates overall pain at 5/10)
1 Decreased swelling 1 Increased Strength 1 Increased ROM 1 Increased Function

Comments: Gertrudes left foot pain is less and AROM left ankle DF 3, PF 45. She reports left heel is numb and Wbearing or severe effort at DFlexion are causing shooting pain over medial planter nerve course. She no longer exhibits positive Tinel's and edema/temperature has improved. She is independent with HEP of ROM, t-band ex, Heel cord string stretch and is unable to tolerate WBearing ex or stretch at this time. She has mild antalgic limp, weakness, pain, numbness, and limited ROM Left ankle. She has completed a maximum course of iontophoresis. Plan: D/C PT on Home program at this time due to inability to tolerate further progression of RX.

RECOMMENDATION:

☒ Therapy is offering no relief

☐ Making progress: continue therapy _____ days/week for _____ weeks with new goals of:

- 1.
- 2.
- 3.

☐ Good Progress; discharge to Home Program

☐ Goals Met; Discharge from Physical Therapy

Therapist's Name Dorothy Mackinnon

PHYSICIAN: Thank you for this referral. Please see recommendations above.
 If you concur, please sign below. If you have revisions for this
 Patient's care please advise:

Discharge from PT

Martin Durkin
 Physician's Signature

**** Please send signed paper back with patient,
 if continued treatment is desired.

OR

Return to: Palmetto Richland Rehabilitative Care Center
 14 Richland Medical Park Drive, Suite 100, Columbia, SC 29203
 Phone: (803) 434-2500 Fax: (803) 434-3732

(543)

247
 PPT
 1/20

* Final Report *

Result Type: CR Chest 2 Views PA + Lateral
Result Date: 24 October 2003 2:40
Result Status: Auth (Verified)
Verified By: Bayard MD, Walter J on 24 October 2003 14:37
Encounter info: Richland, ERR-Emergency Room, 10/24/2003 - 10/24/2003

* Final Report *

Reason For Exam
786.50-CHEST PAIN NOS

Impression:
CHEST, TWO VIEWS 10/24/2003

CLINICAL HISTORY: Blunt trauma. The patient complains of chest wall pain.

PA and lateral views reveal the lungs to be normally expanded and clear. The cardiomediastinal silhouette is normal. No pleural abnormalities are identified.

IMPRESSION:

NORMAL.

Signature Line

*** Final ***

Read by: Bayard MD, Walter J
Released By: Walter J. Bayard
on: 10/24/2003 14:37

Transcriptionist: SDH

Trans Date/Time: 10/24/2003 14:10

Technologist: Mcfarland, Kelly L, Bouknight, Traci L

Completed Action List:

- * Perform by Wooten, Kelly L on 24 October 2003 2:40
- * Assist by Bouknight, Traci L on 24 October 2003 2:40
- * VERIFY by Bayard MD, Walter J on 24 October 2003 14:37

Printed by: Maslow RN, Debra H
Printed on: 3/9/2006 8:12

Page 1 of 2
(Continued)

(544)

8/16
ImageCare, LLC-CPG
710 Rabon Rd
Columbia 29203
Phone: (803)462-3680

Name: Gertrude Shiver #71705
Patient ID: 1000021995
DOB: 5/19/1954
Phone: (803)353-3892
Acc#: 42610

Exam Date: 8/17/2004
Exam: Ribs (unilateral)
Reason: 786.50 - PAIN, RIB
Referrer: JEFF HOOK-CPG
2nd Referrer:

Results

DATE EXAM PERFORMED: 8-16-04

HISTORY: Fall

FINDINGS: AP and oblique views of the left ribs were submitted for interpretation. The left thorax appears to be intact with no evidence of acute fracture.

Steve Glassman, MD

Transcribed By: Dee Dee Martin
Transcribed Date: 8/18/2004
Interpreting Rad: Steve Glassman, MD
Finalized Date: 8/18/2004

Pt. Name: Gertrude Shiver #71705
Patient ID: 1000021995
Exam: Ribs (unilateral)
Acc: 42610

mottly rib films
normal. No old or
acute frx seen. No
other lesions noted.

DM
06/18/04

(dict 8/16)

9-18-04

(545)



Palmetto Health Richland
5 Richland Medical Park
Columbia, SC 29203

Patient Name: **SHIVER, GERTRUDE**
Patient Address: 1026 CONGAREE CHURCH ROAD
GADSDEN, SOUTH CAROLINA 29052
Patient Telephone: (803) 353-3892

Hook MD, Jeffery D
3000 NE MEDICAL PARK
SUITE 108
COLUMBIA, SC 29223

Date of Birth: 5/19/1954
SSN: 249-98-2546
Medical Record Number: R009952117
Account Number: R0611101072
Location: , Patient Type: OQR-Outpatient Quick Reg
Room Number:
Ordering Physician: Hook MD, Jeffery D
CC:

R A D I O L O G Y S E R V I C E S

Exam:	Exam Date/Time:	Accession Number:	Ordering Physician:
CR Ribs Unilateral Left W/ PA Chest	4/21/2006 1:04:32 PM	CR-06-060418	Hook MD, Jeffery D

Reason for Exam:
RIB / CHEST PAIN

Findings:
LEFT RIBS:

CLINICAL HISTORY: LEFT RIB AND CHEST PAIN.

FOUR VIEWS.

COMPARISON: CHEST RADIOGRAPH OF 10-24-03.

No fractures are identified. No evidence of infiltrates or effusions are identified. No evidence of a pneumothorax is noted. The heart is borderline in size.

CONCLUSIONS:

Left
4/24/06
gb

Patient Name : SHIVER, GERTRUDE

Chart ID: 3812212

Page 1 of 1

PHR RadNet Ordering Physician
Hardcopy and Fax
Print Date/Time: 4/21/2006 4:10 PM

(546)

Moore Orthopaedics
14 Medical Park, Suite 200
Columbia, South Carolina 29203
(803) 227-8000 Phone / (803) 227-8017 Fax

July 21, 2006

Gertrude Shiver 218248

Richland Office

CHIEF COMPLAINT:

BILATERAL KNEE PAIN AND LEFT WRIST PAIN

HISTORY OF

PRESENT ILLNESS:

Ms. Shiver is a pleasant 52-year-old female who is here for the above-mentioned complaints. She is seen over at the kind request of Dr. William Robinson. She states that on 05/20/06, she unfortunately fell, landing on both knees and both wrists. She states she was able to walk right afterwards and felt she just bruised her knees but has been having persistent pain. She did get x-rays done by Dr. Robinson and no fractures were identified. However, her symptoms have not abated. She is kindly referred here for initial evaluation and treatment. She has no popping or giving way really but just anterior knee pain bilaterally and left wrist pain without numbness. She has pain in both wrists after extension.

REVIEW OF SYSTEMS:

The patient's medical history form is reviewed with the patient, signed, and is included in the chart.

PHYSICAL EXAMINATION:

Examination reveals the patient is generally alert, oriented and appropriate. Gait is normal. Examination of bilateral knees shows there is no skin abnormality to inspection. Sensory examination is normal to light touch. There is no effusion present in either knee. Lachman, posterior drawer test, medial and lateral collateral ligament stress tests are negative for the bilateral knees. Posterior lateral drawer is negative bilaterally. There is no tenderness in the patellar tendon or quadriceps tendon bilaterally. Patellar apprehension test is positive, greater on the right than the left. Pivot shift test is negative. Knee range of motion is 0 to 140° in the bilateral knees. Hip range of motion is within normal limits with symmetrical internal and external rotation, hip flexion and extension. Medial and lateral joint lines are non-tender. McMurray's maneuver is negative. Neurological examination shows symmetric 2+ deep tendon reflexes at the bilateral knees and ankles. Quadriceps strength is 5/5 bilaterally. There is a palpable dorsalis pedis pulse. Flexion and extension of the toes is normal. There is no sensory deficit to light touch on the plantar dorsal foot.

Examination of the left wrist reveals negative Finkelstein tests bilaterally. She has 10 degrees dorsiflexion and plantarflexion bilaterally. Watson test is negative. She is tender over the FCR tendon and the flexor digitorum tendon. Examination of the right wrist reveals mild diffuse dorsal radiocarpal tenderness without swelling.

RADIOGRAPHS:

X-rays include three views of the left wrist from June, which are normal, at an outside facility. X-rays also include three views of bilateral knees, which are normal.

-continued-

(542)

Moore Orthopaedics
14 Medical Park, Suite 200
Columbia, South Carolina 29203
(803) 227-8000 Phone / (803) 227-8017 Fax

July 21, 2006

Gertrude Shiver 218248

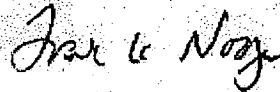
Richland Office

IMPRESSION:

1. CONTINUED PATELLOFEMORAL SYNDROME, BILATERAL KNEES
2. LEFT WRIST TENDINITIS
3. BILATERAL WRIST SPRAINS

PLAN:

I am going to place her in wrist braces today and put her in physical therapy for the wrists and the knees. I would like to see her back in six weeks.



Frank K. Noojin, M.D.

FKN:hma

(Next appointment: Six weeks)

cc: William Robinson, M.D.

DD: 07/21/06, DR: 07/21/06, DT: 07/24/06

Ammended 11/09/2007

ADDENDUM: According to the patient's history, she developed some pain in her right wrist after using a hole punch on July 16th when working at Palmetto Health Richland in medical records.

Frank K. Noojin, III, M.D.

CC List:

FKN:ats32

DD: 03/05/2010 DT: 03/08/2010 13:44:11

26009

(548)

The Moore Orthopaedic Clinic, P.A.
14 Medical Park, Suite 200
Columbia, South Carolina 29203
PH: (803) 227-8000 FAX (803) 227-8012

September 01, 2006

Gertrude Shiver 218248

Richland Office

PRESENT CONDITION:

Gertrude returns for both wrists. Her wrists are still hurting her. Her left knee is better, but she still has some right knee pain.

REVIEW OF SYSTEMS:

The patient's medical history form is reviewed with the patient, signed, and is included in the chart.

PHYSICAL EXAMINATION:

She has no effusion in either knee. She has 0 to 130 degrees knee range of motion bilaterally. The joint lines are nontender. Her patella is apprehensive with some evidence of maltracking noted today.

Examination of both wrists reveals 10 degrees of dorsiflexion and plantarflexion. Negative Lachman signs bilaterally. There is no palpable tenderness but just diffuse tenderness. Finkelstein's test is negative bilaterally.

RADIOGRAPHS:

X-rays include four views of bilateral wrists including clenched fist view, which show no abnormalities taken on the PACS system here.

IMPRESSION:

1. BILATERAL WRIST PAIN AND TENDONITIS
2. PATELLOFEMORAL SYNDROME, RIGHT KNEE

PLAN:

We are going to continue therapy and I will see her back in six weeks and anticipate release at that time. I will try her in a PTO brace for the right knee today.

Frank K. Noojin, M.D.

FKN: jvd

(Next appointment: Six weeks)

cc: William Robinson, M.D.

DD: 09/01/06, DR: 09/01/06, DT: 09/02/06 DP: 09/05/06

(549)

Moore Orthopaedics
14 Medical Park, Suite 200
Columbia, South Carolina 29203
PH: (803) 227-8000 FAX (803) 227-8017

October 12, 2006

Gertrude Shiver A218248

Richland Office

PRESENT CONDITION:

Ms. Shiver returns for her right knee and both hands. The right knee has continued having problems. The left knee is doing fine. She had been to physical therapy for the wrists and hands and the right knee.

PHYSICAL EXAMINATION:

On examination today, she has full range of motion of the knee without effusion. The joint lines are nontender. Examination of hands reveals a deep tenderness present dorsally over the radial aspect of the wrist. She is able to flex and extend her fingers. She has no Tinel's sign bilaterally, although she has some subjective numbness to both the long and the ring fingers of bilateral hands.

IMPRESSION:

1. WRIST TENDINITIS WITH POSSIBLE MILD CARPAL TUNNEL SYNDROME
2. PATELLOFEMORAL SYNDROME, RIGHT KNEE

PLAN:

Home exercise program. She can do her regular job but we will prefer not to do a lot of repetitive work with her hands at this point.

Frank K. Noojin, M.D.

FKN:sps

cc: William K. Robinson, M.D.

DD: 10/12/06, DT: 10/13/06 DP: 10/17/06

(550)

Moore Orthopaedics
14 Medical Park, Suite 200
Columbia, South Carolina 29203
(803) 227-8000 Phone / (803) 227-8017 Fax

November 22, 2006

Gertrude Shiver 218248

Richland Office

PRESENT CONDITION:
is still not getting any better.

Ms. Shiver returns for both wrists and her right knee. She

PHYSICAL EXAMINATION: On examination today, she has full range of motion in both wrists. No focal point of tenderness. Lachman test is negative. Snuffbox is nontender. Examination of the right knee reveals anterolateral patellar tenderness without effusion. Full range of motion. Stable knee.

RADIOGRAPHS: X-rays including two views of right knee obtained today were normal. X-rays of both wrists obtained today including scaphoid views shows no abnormalities.

IMPRESSION:

1. BILATERAL WRIST PAIN, IMPROVED
2. PATELLOFEMORAL SYNDROME, RIGHT KNEE

PLAN: She has tried a lot of treatments. I am going to recommend continued physical therapy. We will keep her on light duty, which would be mostly sedentary type work at this juncture. I will see her back in six weeks. I think she will be MMI at that time.

Frank K. Noojin

Frank K. Noojin, M.D.

FKN: rpg

DD: 11/22/06, DT: 11/23/06

(551)

Moore Orthopaedics
14 Medical Park, Suite 200
Columbia, South Carolina 29203
(803) 227-8000 Phone / (803) 227-8017 Fax

January 17, 2007

Gertrude Shiver 218248

Richland Office

PRESENT CONDITION:

Ms. Shiver returns for her right knee and both wrists. She is doing better. She still has some pain in the left wrist and the right knee. She has been to therapy.

REVIEW OF SYSTEMS:

The patient's medical history form is reviewed with the patient, signed, and is included in the chart.

PHYSICAL EXAMINATION:

On physical exam, she has 0 to 130 degrees knee range of motion bilaterally. There is no effusion. Patella is mildly apprehensive. Joint lines are nontender. Wrist has 70 degrees dorsiflexion and palmar flexion bilaterally.

IMPRESSION:

- 1 RESOLVING BILATERAL WRIST SPRAIN
- 2 PATELLOFEMORAL SYNDROME, RIGHT KNEE

PLAN:

At this point, I think she is at maximum medical improvement. She is seven months since her injury. She apparently got terminated from her previous employment. She has already completed course of physical therapy. I am going to go ahead and release her, and I will see her back as necessary.

Frank K. Noojin

Frank K. Noojin, M.D.

FKN:sps
cc: William K. Robinson, M.D.
DD: 01/17/07, DT: 01/18/07
Voice File: FKNO1349, 00:00

(552)

January 17, 2007

BCBS-SC: BCBS OF SC (PPO)[28671]
Piedmont Service Center
Greenville, SC 29606

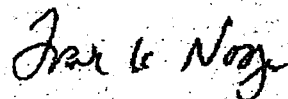
RE: Gertrude Shiver
EMPL:
DATE OF INJURY:

Dear Sir/Madam,

Regarding Gertrude Shiver's injury to the right knee, I believe Maximum Medical Improvement has been attained. The final diagnosis for Gertrude Shiver remains patellofemoral syndrome, right knee, and resolved bilateral wrist sprains. According to the 5th Edition of the American Medical Association's Guidelines to the Evaluation of Permanent Impairment, I think she is entitled to 10% impairment rating to the right lower extremity for patellofemoral disorder and 2% impairment rating to each upper extremity for wrist sprain that has resolved.

Gertrude Shiver is discharged from my care at this time. I would be happy to be of assistance in the future should this be necessary. Please do not hesitate to contact me should you have any further questions or require any additional information.

Sincerely,



Frank K. Noojin, III, MD

(553)

PATIENT INFORMATION

Name SHIVER, GERTRUDE

Date 8/04/06

Diagnosis:

(B) Wrist Sprain (7/17-7)
(B) P.S. (7/19/06)

Treatment:

(P/12) MD

- 1) DT eval
- 2) MH (B) Knee x10
- 3) CX ASDCC (B) Wrist + knees
- 4) Home Mgmt - issued written HEP for (B) Wrist / (B) Knee, issued pat h #2 use of heat/ice @ home

History:

See dictation.

C. B. Blue

COLUMBIA REHABILITATION CLINIC, INC
INITIAL EVALUATION

Date: August 4, 2006

Re: Gertrude Shiver

MD: Dr. Noojin

DX: ~~Bilateral wrists sprain (717.7 and bilateral patellofemoral syndrome (719.46).~~

SUBJECTIVE HISTORY: This is a very pleasant female who was referred to us with the above diagnosis. The patient reports a fall in which she landed on her right wrist and both knees causing pain and she also reports her left wrist being strained at work with repetitive tasks. The patient reports initial x-rays of the left wrist and both knees were negative by her family physician and she was referred to Dr. Noojin and he diagnosed her with bilateral patellofemoral syndrome and bilateral wrist sprains/strains and then referred to physical therapy. The patient's medications include Ultram. Next follow-up with Dr. Noojin is on September 1, 2006.

PMH is as listed in chart. Medications are as listed in the chart.

OBJECTIVE EXAMINATION:

Pain: Patient rates her left knee pain a 3/10 and right knee pain a 5/10 and she rates her bilateral wrist pain a 4-5/10.

Strength:

Grip Strength: Right hand 30 lbs versus left hand at 20 lbs.

Bilateral Quads - Grossly 4-/5 with c/o quad sets.

AROM

Right Wrist - Flexion 60°, extension 35°, ulnar and radial deviation WNL.

Left Wrist - Flexion 50°, extension 40°, ulnar/radial deviation WNL.

Bilateral Knees - WNL

Effusion/Girth: Measurement left mid patella 16 1/2" versus right mid patella at 16".

Sensation: Intact to light touch throughout both hands and both lower extremities.

Palpation: Diffuse tenderness at both wrists through the volar aspect with the right being greater than the left. Tender with palpation to the patella tendon bilaterally.

ASSESSMENT: Patient presents with bilateral wrist sprains and patellofemoral syndrome with weakness, tightness in the hamstrings and pain with ADL's such as ascending and descending the steps, as well as pain with bilateral wrist AROM for ADL's. The patient is an excellent candidate for skilled PT.

(555)

Page 2

Re: Gertrude Shiver

Short Term Goals:

(2 weeks)

1. Patient to be independent with written HEP.
2. Patient to report a 25% decrease in pain.
3. Increase AROM at both wrists for flexion/extension by 5-10°.

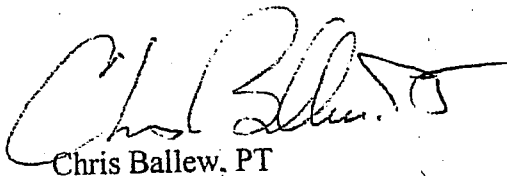
Long Term Goals:

(4 weeks)

1. Patient to be 80-90% symptom free.
2. Patient's ROM to be WNL throughout both wrists.
3. Patient's strength to increase by 10 lbs. for grip strength at both hands.
4. Patient's quad set to increase by one-half MMT grade.

Prognosis: Good

PLAN: Plan to see patient in physical therapy 2 x weekly over the next 6 weeks as per ordered by MD for patient education, ROM, stretching, strengthening/stabilization, mobilization, and modalities as needed.



Chris Ballew, PT

CB/jc

(556)

PROGRESS NOTES

Date

Name

Shiver, Gentile

AUG 09 2006

S: (B) KNEE SWELLING

O: MHP X 10 MINS (B) ANT. KNEE

EX COMPLETED AS CHARTED

 $\frac{2}{12}$

#5/REP'S

ADDED: KNEE ✓ / NOT SQUATS / Calf RAISES /
 STEP-UPS / ABD / WRIST SUP + PRON;
 ULD + RADIAL DEN.

ICE PACK (B) KNEE X 15 MINS.

A: TOL + EX PROGRAM - NO ADVERSE SV

P: CONT. + E. PT. TOL

AUG 11 2006

S: MILD SWELLING (B) WRIST P + EX PROGRAM

 $\frac{3}{12}$

O: MHP X 10 MINS (B) ANT KNEE

EX COMPLETED AS CHARTED

#5/REP'S

ICE PACK X 15 MINS @ ANT. KNEE

A: EX WITHIN TOL RANGE; GAINING + LE STRENGTH

P: CONT.

AUG 14 2006

S: (B) KNEE CONT'S GIVE ME PROBLEMS.

 $\frac{4}{12}$

O: MHP X 10 MINS (B) ANT. KNEE'S

EX COMPLETED AS CHARTED

#5/REP'S

ICE PACK (B) KNEE X 15 MINS.

A: WORK WITHIN TOL RANGE

P: CONT.

(557)

PROGRESS NOTES

Date

Name

Shiver, Gertrude

AUG 16 2006

O: MHP x 10 MINS (B) KNEE'

5
12

EX COMPLETED AS CHARTED

B's / REP'S

ICE PACK (B) KNEE x 15 MINS

A: GRADUAL PROGRESS

P: CONT.

8-17-06

S: GRADUAL PROGRESS (A) KNEE (B) KNEE 9+5'

O: MHP x 10 MINS (B) KNEE

EX COMPLETED AS CHARTED

5
12

B's / REP'S

ICE PACK (B) KNEE x 15 MINS.

A: CONT TO PGM + STRENGTH / ENDURANCE

P: CONT.

AUG 21 2006

O: EX COMPLETED AS CHARTED

2
12

B's / REP'S

VBE 5 MINS (B)

(C)

ICE PACK (B) KNEE'S x 15 MINS.

A: GRADUAL + STRENGTH ; (C) LAT KNEE SX'S PERCENT

A CONT.

AUG 23 2006

S: J.SX (C) Knee / wrist, SX Phasit
& (C) Lat Knee ADLS8
12

O: T?x 1) EX as dec E ↑ ↓ Pgs / #

2) ice x 15 (B) Knees

3) modal US & HC 1.54/cm² (C) Lat K

ABER wrist (B) Knees + wrists

A: Progress E current P

P: cat Pold monts @ @ Lat. Knee
(558) 7/2/11. 12

PROGRESS NOTES

Name

Shiver Gertrude

Date

AUG 25 2006

S: MRD A IN (R) MED KNEE SK' P US RX

9
12O: US @ 1.5 N/CAL² TO (R) MED KNEE (SITTING)

EX COMPLETED AS CHARTED

#1's / REP'S

ICE PACK X 15 MINS (R) KNEE

A: ↑ STRENGTH (R) LE

P/C SLR DUE TO CONT. LOW BACK PAIN

P: CONT.

AUG 28 2006

S: CONT'S C/O (R) LAT PATELLA DISCOMFORT

12
12O: US @ 1.5 W/CAL² (R) MED / KNEE (SITTING)

EX COMPLETED AS CHARTED

#1's / REP'S

ICE PACK X 15 MINS (R) KNEE'S.

A: PT. PERFORMED EX & NO COMPLAINTS

C/O (R) WRIST STIFFNESS / PAIN SEVERAL TIMES

(R) LAT PATELLA DISCOMFORT; TENDERNESS

PALPABLE

P: CONT.

AUG 30 2006

O: US @ 1.5 W/CAL² (R) MED / LAT KNEE

EX COMPLETED AS CHARTED

11
12

#1's / REP'S

ICE PACK X 15 MINS (R) KNEE

A: ↑ STRENGTH (R) KNEE SK'S ↑↑

P: MD NOTE

(559)

PROGRESS NOTES

Date

Name

Shirley Gertrude

AUG 31 2006

S: REFER TO MD NOTE

O: US @ 1.5 "/CM² TO (R) LAT KNEE (SITTING)

EX COMPLETED AS CHARTED

 $\frac{1}{12}$

#15/REP'S

(L) + (R) KNEE AROUND WNL'S.

+ TENDERNESS (R) PATELLA REGION

ICE PACK (R) ANT KNEE REGION

P: D/C UNTIL FURTHER MD ORDERS

[Signature]

9-6-06

S: NEW MD ORDERS

O: EX COMPLETED AS CHARTED

 $\frac{2}{12}$

#15/REP'S

ADDED: 10MTD @ DEXA (COMP 80) @ ICE PACK

X 15 WNL'S. (R) LAT PATELLA REGION

A: + TENDERNESS (R) LAT PATELLA REGION

P: MONITOR SK'S

[Signature]

SEP 08 2006

S: VERY LITTLE A P ADDING 10MTD BY

O: EX COMPLETED AS CHARTED

 $\frac{3}{12}$

#15/REP'S

↓ #2 @ WRIST 10/1 DUE TO DISCOMFORT

10MTD @ DEXA (COMP 80) TO (R) LAT PATELLA

REGION @ ICE PACK

A: EX WITHIN TOL RANGE

P: CONT.

(560)

COLUMBIA REHABILITATION CLINIC, INC.
PROGRESS NOTES

Name Shiver, Gertrude

Date

SEP 11 2006

O: EX COMPLETED AS CHARTED

#13/REP'S

① 4
12

ADDED: (R) LE LIDO K₂ 20-85°

100% E DEXA (COMP 80) (R) LAT PATELLA REGION

ICE PACK (B) KNEE

A: TEL & EX PROGRAM (R) LG E NO COMPLAINTS

P: CONT.

[Signature]

SEP 13 2006

S: ↑ ROM / Fun. Ab. / ↓ Pain (75%) Better

1/K 3-4/5

O: Rx 1) Crossdoc

2) ↑ ↓ P₁₀₅ / H

3) Lido (R) K₂ K₂ (20-85°)

4) Lido / dex (R) lat patella

5) ice (B) knee

APRIL WFLS (B) knee + wrist

↓ P₁₀₅ (R) knee 3-4/5, STR (L) knee 4-11/5

(R) knee 4/5

A: Progress made towards goals

P: CONT. *[Signature]*

SEP 18 2006

SEP 20 2006

O: EX COMPLETED AS CHARTED

#13/REP'S DOCUMENTED

4
12

①

LIDO K₂ 20-85°

100% E DEXA (24 HR) (R) PATELLA TENDON

ICE (B) KNEE'S X 15 MIN.

A: PROGRESS E GOALS

P: CONT.

[Signature]

(561)

COLUMBIA REHABILITATION CLINIC, INC.
PROGRESS NOTES

Date

Name

Shiven Gentrude

9/22/06

S: GETTING STRONGER

O: EX COMPLETED AS CHARTED

2
12 (3)

2 1/2 / REPS

LIDO K₂ 20-85 (R)

100% E DEXA (24 HR) (R) PATELLA TENDON

ICE PACK (B) KNEE'S X 15 MINS.

A: + STRENGTH (R) LAT PATELLA SX'

P: CONT.

SEP 25 2006

S: 4+ WRIST DISCOMFORT

O: EX COMPLETED AS CHARTED

3
12 (3)

2 1/2 / REPS

LIDO K₂ 20-85 (R)

100% E DEXA (24 HR/COMP) (R) PATELLA TENDON

ICE PACK (B) KNEE'S X 15 MINS.

A: 4+ IMPROVEMENT E LE / WRIST

P: CONT.

SEP 27 2006

O: EX COMPLETED AS CHARTED

2
12 (3)

2 1/2 / REPS

LIDO K₂ 20-85 (R) LE

100% E DEXA (COMP) (R) PATELLA TENDON

ICE PACK (B) KNEE'S X 15 MINS.

A: + STRENGTH (B) HANDS / KNEE'S

(R) PATELLA SX'S ++

P: CONT.

(567)

COLUMBIA REHABILITATION CLINIC, INC.
PROGRESS NOTES

Date

Name

Amir Baraka

OCT 02 2006

S: A LITTLE IMPROVEMENT @ KNEE

12/12 @

"THE BONE STILL HURTS"

O: EX COMPLETED AS CHARTED

#15/REP'S

LIDO K₂ 25-85

ICE PACK @ KNEE x 15 MINS

IONTO @ DATA @ PATELLA TENDON REGION

P: CONT.

OCT 04 2006

O: EX COMPLETED AS CHARTED

12/12 @

#15/REP'S

LIDO K₂ 25-85

IONTO @ DATA @ LAT. PATELLA REGION

A: ↑ STRENGTH / ↑ PAIN ↓ TENDERNESS /

DISCOMFORT DEBIST @ LAT. PATELLA REGION

P: CONT.

OCT 11 2006

S: REFER TO MD NOTE

O: EX COMPLETED AS CHARTED

12/12 @

#15/REP'S

LIDO K₂ 25-85

IONTO @ DATA @ LAT PATELLA TENDON

A: PT. HAS SHOWN ↑ STRENGTH ↑ PAIN TOLERANCE

1/2 INTERMITTENT TINGLING @ HANDS

@ PATELLA SV

P: D/C UNTIL FURTHER MD ORDERS

(563)

COLUMBIA REHABILITATION CLINIC, INC.
PROGRESS NOTES

Date

Name

Shiver, Gertelude

11-30-de 5: Pt states (B) wrist are st. 11 hurting and
her (B) knee. x-rays of (B) wrists and (B) knee (-)
1/12 Pt states she has been doing house
at home. Pt states her wrists and knee
are better. Pt states she is no longer employed.
O: - tender over lat/distal aspect of patella.
- mmf. - $\sqrt{4/5}$, $\sqrt{4/5}$
- Rom - 0-130°
- (-) swelling 1 1/2" (B) - mid patella.
- good patella mobility
- See up sheet -
Ice x 15 min
- Pt has notable atrophy in (R) lower extremity
4" below tibial tuberosity
(L) 14 1/2 (R) 13 1/2
5" above tibial tuberosity
(L) 18 1/2 (R) 17
8" above tibial tuberosity
(L) 22 (R) 20 1/2
A: Pt presents w/ strength, ↑ atrophy in (R) LE
STG - ↓ pain 50%
Inst in H&P
↑ strength - ↓ atrophy
LTG - ↓ pain 75-80%
(L) H&P
Strength WNL
P: Cont 2x weekly
(564) Laura Johnson P.T

COLUMBIA REHABILITATION CLINIC, INC.
PROGRESS NOTES

Date

Name Shirley G. Trude

12-6-06 S: pt still about same as last visit
 cont'do wrist pain too

O: Therapies
 PC 12 4000 (in knee)

A: NO pain do (in knee) in is
 R. at

DEC 08 2006

S: Pt states her knees are feeling
 better.

O: Seen short - 1 eps

Exercise ready to do (in knee) x 15 min

A: Pt did well in progress

P: Cost

Anna Johnson P.T

DEC 11, 2006

S: Pt reports (in knee) is still injured knee cap.

O: The ex os doe

- P'd resist to steps.

- modified its strength + Ball/well squats

ES 6.R to (in knee) x 15

A: Pt noted saw descent to (in knee) while putting heel steps
 on block steps up.

P: Cost to Pt - ~~blat~~ that all walk without
 short

DEC 15 2006

S: "feels little better"

O: Therapies

PC 12 4000 x 15 (in knee)

A: still no Pt pain (in knee)

P: Cost

(565)

COLUMBIA REHABILITATION CLINIC, INC.
PROGRESS NOTES

Date

Name

Shirley Getrude

12/18/06 S: pt stills cont to make progress
 O: Therapy added: Ther
 PC 408 X2
 A: I'd like patellar band pain
 P: at

DEC 22 2006

O: Pt Rk cont to make progress
 (1-2-3-4-5-6-7-8-9-10)
 * Rk 100% in pt
 A: Good cont to Rk therapy
 P: To MD? JG, PT

DEC 28 2006

S: ↑ soreness on (R) over last 2 days.
 O: Ther-ex (see flowsheet) - modifying
 * (R) PF taping eliminated (R) "pop"
 + ↓ (R) knee pain in step ex
 A: PF tape resulted in ↓ pain on NO pain
 in ex.
 P: cont. in LE str. recommended (R) PF
 tape (for correction of infer tilt & lat tilt)
 (Shirley) Bright PT

12/29/06

O: Ther ex as charted -
 (R) PF taping

A: No popping in prone knee ✓ only

P: Cont

JAN 04 2007

S: pt stills have maybe little better

10/12

O: Therapy in Patella Art Taping (Kinesiology)
 A: I'd like pt to rest, at

(566)

COLUMBIA REHABILITATION CLINIC, INC.
PROGRESS NOTES

Date _____

Name

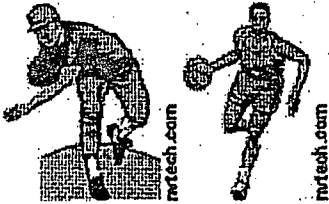
Shiver Gehrude

1/5/07 S: Pt states @ knee feeling better 2nd type to patella
O: Applied McConnel tape to provide medial glide & inferior
medial rotation
- Ther Ex as doc.
- Added Vmo EoEd lift.
- G.R. to @ knee x 10' @ 50°
A: Pt did note some discomfort & the press. tape 2nd
why tape was not tight enough.
P: Cont to rx

1/12/07 S: Strange smell, still having pain
CS: The company, no rest
Ice + @ 1000

~~A. van de putte~~
put

1) 1 per no



The Sports Medicine Center



8-4-06
 @ 2:30pm

Or
The Moore Orthopaedic Clinic
"Celebrating over 75 years of quality care"

Name: Gertrude Shiver

Date: 7-26-2006

Diagnoses: Wrist Sprain & 7177-BI (Patella Maltracking)

Appointment Date: _____

Time: _____

Physical Therapy: To be seen 2 times per week for 6 weeks.

Protocol:

KNEE

ACL pre-op _____
 ACL autograft _____
 ACL allograft _____
 ACL HS _____
 ACL deficient _____
 PCL PTG _____
 MCL _____
 ACL&PCL recon _____
 Lateral ret release _____
 Cartice _____
 Meniscus repair _____
 Patella Protection _____
 Meniscectomy _____
 Fulkerson _____
 PF Program X

SHOULDER

Impingement acute _____
 Impingement subacute _____
 Impingement strength _____
 Impingement advanced _____
 Rot Cuff repair type 1 _____
 Rot Cuff repair 2 _____
 Rot Cuff repair 3 _____
 Bankart repair _____
 SLAP repair _____
 Open Capsulolabral recon _____
 Bristow procedure _____
 Anterior Capsular shift _____
 Posterior Capsular shift _____
 Thermal assist capsulorrhaphy _____
 Anterior shoulder instability _____
 AC joint stabilization _____
 Total shoulder arthroplasty _____

ELBOW

Ulnar nerve trans _____
 UCL sprain _____
 UCL recon _____
 Elbow arthrolysis _____

ANKLE

Ankle sprain I _____
 Ankle sprain II _____
 Ankle sprain III _____
 Brostrom _____

SPINE

Lumbar stabilization _____
 SIJ _____
 Spindylolysis _____

MODALITIES

_____ Cold
 _____ Heat
 _____ Ultrasound
 _____ Phonophores
 _____ E-stim
 _____ Iontophores
 _____ TENS
 _____ Edema Control
 _____ FCE

Other: Wrist modalities

Special Considerations: _____

Weight bearing status: NWB _____ PWB _____ WBAT X

ROM: PROM _____ AAROM _____ AROM X LIMITS _____

Doctor Signature(Dispense as written)

Doctor Signature(Substitution permitted)

(568)



MOORE

— Orthopaedics —

Name: Gertrude ShiverDate: 11-27-2006Diagnoses: 717:7-rt knee, bi wrist sprain

Appointment Date: _____

Time: _____

Physical Therapy: To be seen 2 times per week for 6 weeks.Protocol: Eval and Treat**KNEE**

ACL pre-op _____
 ACL autograft _____
 ACL allograft _____
 ACL HS _____
 ACL deficient _____
 PCL PTG _____
 MCL _____
 ACL&PCL recon _____
 Lateral ret release _____
 Cartice _____
 Meniscus repair _____
 Patella Protection _____
 Meniscectomy _____
 Fulkerson _____
 PF Program X

SHOULDER

Impingement acute _____
 Impingement subacute _____
 Impingement strength _____
 Impingement advanced _____
 Rot Cuff repair type 1 _____
 Rot Cuff repair 2 _____
 Rot Cuff repair 3 _____
 Bankart repair _____
 SLAP repair _____
 Open Capsulolabral recon _____
 Fulkerson _____
 Anterior Capsular shift _____
 Posterior Capsular shift _____
 Thermal assist capsulorraphy _____
 Anterior shoulder instability _____
 AC joint stabilization _____
 Total shoulder arthroplasty _____
 Bristow procedure _____

ELBOW

Ulnar nerve trans _____
 UCL sprain _____
 UCL recon _____
 Elbow arthrolysis _____

ANKLE

Ankle Sprain I _____
 Ankle Sprain II _____
 Ankle Sprain III _____

SPINE

Lumbar Stabilization _____
 SIJ _____
 Spondylolysis _____

MODALITIES

_____ Cold
 _____ Heat
 _____ Ultrasound
 _____ Phonophores
 _____ E-stim
 _____ Iontophores
 _____ TENS
 _____ Edema Control
 _____ FCE

Other: _____

Special Considerations: _____

Weight Bearing Status: _____

NWB: _____

PWB: _____

WBAT: X

ROM: _____

PROM: _____

AAROM: _____

AROM: X

LIMITS: _____

Love & Noy

Doctor Signature(Dispense as written)

Doctor Signature(Substitution permitted)

(569)

Director, M.Ed., P.T.
Director



Columbia
Rehabilitation
Clinic, Inc.

2362 Two Notch Rd.
Columbia, SC 29204
799-7007 - Fax 256-8410

3000 Northeast Medical Park
Columbia, SC 29223
736-4845 - Fax 736-8674

4350 St. Andrews Rd.
Columbia, SC 29210
772-2735 - Fax 798-5514

1177 Sunset Blvd
W. Columbia, SC 29169
794-3440 - Fax 791-3862

PHYSICAL THERAPY PROGRESS UPDATE

PATIENT: GERTRUDE SHIVER DATE: 12/11/06

DIAGNOSIS: (B) WRIST SPRAIN PHYSICIAN: DR. NOOSIN

I. TREATMENT INFORMATION

A. Date of Evaluation 8/4/06 Last Summary 8/30/06
B. Number of Treatments to Date _____ Cancellations _____ No Shows _____
C. Treatment Techniques ROM / PRG'S / ICE & RNTD (DEXA)
D. Modalities _____
E. Home Program ROM / PRG'S / ICE

II. SUBJECTIVE INFORMATION

A. Pain Intensity (0-10) _____
B. Symptoms PT. STATES + STRENGTH (B) LE (B) PATELLA DISCOMFORT
WRIST % TINGLING OCCASIONAL (B) HANDS.

III. OBJECTIVE INFORMATION

A. ROM ADOM (B) WRIST WNL'S
ADOM (B) KNEE WNL'S
B. MMT _____
C. Girth _____
D. Sensation TINGLING SENSATION (B) HAND / FINGER'S
E. Observation/Palpation _____
F. Other _____

IV. ASSESSMENT

PLEASE EXAMINE SR'S ADVISE ; POSSIBLE CONT
& HOME EXERCISE PROGRAM

V. RECOMMENDATIONS / PLAN

A. Request to Continue P.T. _____

(If Continue P.T. complete report on right and return)

B. Discharge from P.T. JW HEP
Reasons for D/C _____

[Signature]
Physical Therapist

PRESCRIPTION

Total Visits: _____ x / week _____ weeks

Continue P.T. _____

Area to be treated: _____

Any Changes: _____

Contraindications: _____

MD

Date

10

(370)

Bruce D. Filler, M.Ed., P.T.
Director



Columbia
Rehabilitation
Clinic, Inc.

2362 Two Notch Rd.
Columbia, SC 29204
799-7007 · Fax 256-8410

3000 Northeast Medical Park
Columbia, SC 29223
736-4845 · Fax 736-8674

4350 St. Andrews Rd.
Columbia, SC 29210
772-2735 · Fax 798-5514

1177 Sunset Blvd
W. Columbia, SC 29169
794-3440 · Fax 791-3862

PHYSICAL THERAPY PROGRESS UPDATE

PATIENT: Shiver, Gertrude DATE: 1-12-07

DIAGNOSIS: RFS (R knee) PHYSICIAN: Dr. Nguyen

I. TREATMENT INFORMATION

A. Date of Evaluation 11/30/06 Last Summary _____
B. Number of Treatments to Date 12 Cancellations _____ No Shows _____
C. Treatment Techniques Stretching, Strengthening
D. Modalities Ice
E. Home Program ✓

II. SUBJECTIVE INFORMATION

A. Pain Intensity (0-10) _____
B. Symptoms chief 40 knee cap mal-tracking, popping

III. OBJECTIVE INFORMATION

A. ROM (R knee) ✓: 0° - 125°
B. MMT Strength 4-5 Quads / Hamstrings
C. Girth 1/4 mid patella Girth
D. Sensation Intact
E. Observation/Palpation (+) Medial / Lateral joint line pain
F. Other _____

IV. ASSESSMENT

Dr. Nguyen, nt has made fair progress 2 wk
Still having some pain and popping
maybe Due to quad weakness Please Advise

V. RECOMMENDATIONS / PLAN

A. Request to Continue P.T. ✓
(To Continue P.T. complete script on right and return)

B. Discharge from P.T. _____
Reasons for D/C _____

Marc D. [Signature]
Physical Therapist

PRESCRIPTION

Total Visits: _____ x / week _____ weeks

Continue P.T. _____

Area to be treated: _____

Any Changes: H4P

Contraindications: _____ 13

[Signature] MD Date 1/12/07

(5711)



Charleston Memorial Hospital

326 Calhoun Street • Charleston, South Carolina 29401 • (803) 577-0600

May 17, 1995

Ms. Gertrude Shiver
411 Meeting St. Apt. 4309
Charleston, SC 29403-6242

Dear Ms. Shiver:

Our records indicate that you have not worked since January 1995 in our Nursing Department. In order to maintain your status as a member of Charleston Memorial Hospital's staff, you must work at least two shifts per month. Also, those employees who work in departments providing 24-hour service are required to be available to work on weekends and holidays.

To remain as a member of our staff, you must contact Annette Thompson to schedule an assignment. If Ms. Thompson or myself do not hear from you within two weeks from the date of this letter, I will assume you are no longer interested in being employed by Charleston Memorial Hospital and will terminate your employment at that time.

Should you have any questions please feel free to call me at 953-8349.

Sincerely,

Lynn Campbell

Lynn Campbell
Recruitment Coordinator

none
FA PAI

cc: employee file

(572)

CHARLESTON MEMORIAL HOSPITAL - CHARLESTON, S.C.

602210	03043	249-98-2546	22.00	0	0	S	1/20/95	
NRM HR	8.1	178.20	HERITAGE					75.00
OUR PATIENTS DESERVE NO LESS THAN YOUR TOTAL COMMITMENT TO EXCELLENCE			MTD →					
			64.35					
GROSS EARNINGS	FEDERAL TAX	STATE TAX	SOCIAL SECURITY	MEDICARE	RETIREMENT	DEDUCTION		
178.20	10.13	4.39	11.05	2.58	10.69	75.00		
358.60	20.57	8.87	22.23	5.20	21.51	E.L.C.		

NO. 132777

IN ADDITION CMH PAYS THE FOLLOWING BENEFITS FOR YOU:
 1. RETIREMENT CONTRIBUTION 2. \$1 FOR EACH \$1 OF EMPLOYEE'S SOC SEC
 3. BASIC INSURANCE PREMIUMS: HEALTH, DENTAL, AND LIFE

CHARLESTON MEMORIAL HOSPITAL - CHARLESTON, S.C.

602210	03043	249-98-2546	22.00	0	0	S	2/03/95	
NRM HR	8.1	178.20	HERITAGE					75.00
OUR PATIENTS DESERVE NO LESS THAN YOUR TOTAL COMMITMENT TO EXCELLENCE			MTD →					
			64.35					
GROSS EARNINGS	FEDERAL TAX	STATE TAX	SOCIAL SECURITY	MEDICARE	RETIREMENT	DEDUCTION		
178.20	10.13	4.39	11.05	2.58	10.69	75.00		
536.80	30.70	13.26	33.28	7.78	32.20	E.L.C.		

NO. 132991

IN ADDITION CMH PAYS THE FOLLOWING BENEFITS FOR YOU:
 1. RETIREMENT CONTRIBUTION 2. \$1 FOR EACH \$1 OF EMPLOYEE'S SOC SEC
 3. BASIC INSURANCE PREMIUMS: HEALTH, DENTAL, AND LIFE

APAI

(573)

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715

SCC File # 9503744
Carrier File # 000000067893
Carrier Code # _____
Employer FEIN _____

Gertrude Shiver 249 98 2546
Claimant's Name SSN

Address City State Zip

Home Phone # Work Phone #

E. Douglas Pratt-Thomas

Preparer's Name

Trident Regional Medical Center
Employer's Name

Address City State Zip

Alexsis Risk Management Services
Insurance Carrier

(803) 727-2212

Phone #

The parties named above agree to pay and accept compensation for temporary total disability based on the following terms.

Date of injury: 1/23/95
month day year

3. Date disability began: 1/23/95
month day year

Part of body injured:

4. Average Weekly wage: \$ 825.09

right shoulder; right foot

5. Compensation rate: \$ 422.48

The claimant shall receive weekly payments at the compensation rate beginning on 1/23/95 until terminated
month day year
in accordance with the Workers' Compensation Act and R.67-504 or R.67-507.

The employer and its insurance carrier will pay for authorized medical care only. The compensation rate is subject to adjustment and reduction according to R.67-508.

Gertrude Shiver
Claimant's Signature

E. Douglas Pratt-Thomas
E. Douglas Pratt-Thomas, Atty for
Employer/Carrier

Employer's Representative

8/22/95

Date of Agreement

Witness ☒ Claimant's Attorney
(Check One)

Attorney's Name

Attorney's Address

Attorney's Telephone Number

RESERVED FOR COMMISSION'S USE

SCWCC

SEP 18 1995

This form in duplicate with the Claims Department within 15 days of the date of the agreement. The employer's representative is to insert WCC File number, Carrier File number, Carrier Code number and Employer's FEIN. Refer to R.67-501 through R.67-510.

(574)

South Carolina Workers Compensation Commission
P.O. Box 1715 - 1612 Marion Street
Columbia, South Carolina 29202-1715

WCC File # 9503744
Carrier File #
Carrier Code #
Employer FEIN

BERTRUDE SHIVER 249-98-2546
Claimant's Name SSN

411 Meeting St., # 4309, Chas., SC 29403
Address City State Zip

(803) 577-2904 ()
Home Phone # Work Phone #

THOMAS M. WHITE, ESQUIRE
Preparer's Name

TRIDENT REGIONAL MEDICAL CENTER
Employer's Name

9330 Medical Plaza Dr., Chas., SC 29406
Address City State Zip

ALEXSIS INSURANCE
Insurance Carrier

(803) 572-0700
Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

1. Date of accident: 1/23/95 2. AWW: \$ 753.94 Comp. Rate: \$ 422.48
3. Type of injury: Right arm and shoulder, cervical spine, feet
4. Facts in controversy: The correct amount of Claimant's average weekly wage and applicable compensation rate; amount of temporary total to which Claimant is entitled; whether Claimant has reached maximum medical improvement, and, if so, the amount of loss of use and disability to the Claimant; whether Claimant needs additional medical treatment
5. Legal issues involved: None other than those listed above
6. Unusual problems: None
7. Lay witnesses: Tim Crosand - co-worker who can testify as to Claimant's accident
8. Exhibits: 1994 tax returns and W-2 forms from Chas. Memorial Hospital & Trident Hospital; Letter from Alexsis Insurance dated 2/14/95
9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance) SEE ATTACHED LIST
10. Name, address, and specialty, if any, of the treating physician: Dr. Cook, Dr. Bowles, Dr. Crouch, Charleston, SC
11. Impairment rating(s); body part(s); physician and date of opinion: PREMATURE - Claimant still needs medical care

I certify that I have served this document pursuant to R.67-212 by delivering a copy to E. Douglas Pratt-Thomas, Esquire, at P.O. Drawer O, Charleston, SC, 29402, on the 29 day of July, 1995, by first-class mail.

Signature

On behalf of ☒ Claimant ☐ Employer

July 20, 1995

Date

HEARING DATE: August 11, 1995

File this form and proof of service on the opposing party according to R.67-611 and R.67-212.

WCC Form # 58. Rev. Date 9/90

Pre-Hearing Brief.

(575)

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715

WCC File # 9503744
Carrier File # 000000047893
Carrier Code # _____
Employer FEIN _____

Gertrude Shiver
Claimant's Name
249 98 2546
SSN

Address City State Zip

Home Phone # _____
Work Phone # _____
Preparer's Name E. Douglas Pratt-Thomas

Trident Regional Medical Center
Employer's Name

Address City State Zip
Alexsis Risk Management Services
Insurance Carrier

Phone # (803) 727-2212

1. Date of injury: 1/23/95

2. Temporary Compensation Paid:	Number of Weeks	From	To	Amount
	<u>3</u>	<u>1/23/95</u>	<u>2/12/95</u>	<u>\$ 1,267.44</u>
	_____	_____	_____	<u>\$ _____</u>
	_____	_____	_____	<u>\$ _____</u>

(Complete applicable sentence):

3(a). The claimant returned to work without restriction on 2/12/95
month day year

3(b). The claimant agrees he or she was able to return to work on _____
month day year

I agree that I was disabled for the period indicated and I was paid compensation as shown above. I UNDERSTAND THAT I GIVE UP NO RIGHTS TO COMPENSATION FOR FUTURE DISABILITY, FOR PERMANENT DISABILITY, DISFIGUREMENT, OR MEDICAL CARE. The effect of this form has been fully explained to me, and I have received a copy of it. I understand that I should not sign this form until 15 days after I have returned to work without restriction or agreed I was able to return to work.

Gertrude Shiver
Claimant's Signature

Employer's Representative

8/22/95
Date of Agreement

☐ Witness ☐ Claimant's Attorney
(Check One)

File this form with the Claims Department no later than 31 days from the date the claimant returned to work without restriction or agreed he or she was able to return to work. The employer's representative is to insert the WCC File number, Carrier Code number, Carrier File number, and the Employer's FEIN. Refer to R.67-504 for additional information.

(576)

Receipt of Compensation

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

C. File # 9503/44
File # 938481
Carrier Code # 00253-7
Employer FEIN 570609614

Getrude Shiver 249-98-2546
Claimant's Name SSN
411 Meeting St. #4309 Charleston, SC 29403
Address City State Zip
() ()
Home Phone # Work Phone #
Tom Parsons
Preparer's Name

Trident Regional Medical Center
Employer's Name
9330 Medical Plaza Drive Charleston, SC 29406
Address City State Zip
Continental Insurance Company
Insurance Carrier
(804) 281-0427
Phone #

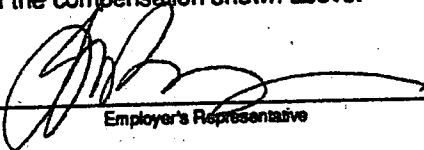
Compensation Paid:	Number of Weeks	From	To	Amount
1. Number of weeks T.T.	3	1/23/95	2/12/95	\$ 1267.44
2. Number of weeks T.P.				\$ 0
3. Number of weeks P.P.				\$ 0
4. Disfigurement				\$ 0
5. Agreement and Final Release				\$ 0
Total Compensation Paid				\$ 1267.44
Total Medical Benefits* Paid				\$ 926.02
7. Funeral Benefits				\$ 0

☐ Case Denied

Date of Injury: 1/23/95
month day year

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____
Claimant

By: 
Employer's Representative

Date: 5/28/97

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of additional Fees and Recoupment

A. Carrier Reimbursement by Third Party

\$ _____

B. Attorney's Fee Paid by Employer

\$ _____

C. Attorney's Fee Paid by Claimant

\$ _____

(Non contingent fees, only)

File this form with the Claims Department according to R.37-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. *Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form 19 must be filed when a claim is denied.

WCC FORM # 19 REV. DATE 3/96

STATUS REPORT AND COMPENSATION RECEIPT

19
(577)

3
STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

SHIVER GERTRUDE

Employee-Claimant,

vs.

TRIDENT REGIONAL MED CTR

Defendant

SOUTH CAROLINA
WORKERS COMPENSATION COMMISSION

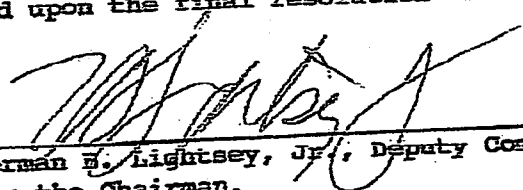
W.C.C. FILE NO. 9457677

ORDER RELIEVING COUNSEL

This matter comes before me by request of Gertrude Shiver that Thomas M. White be relieved as Counsel for the Claimant in above named file.

IT IS HEREBY ORDERED that the above named attorney be relieved as Counsel for the Claimant. It is further ordered that the above named attorney shall not represent the Claimant in any matters concerning the above named Workers' Compensation claim which arise after the date of this Order.

Pursuant to R.67-1203, the above named Attorney may request approval of attorney's fees, if any, by filing a Form 61 (Attorney Fee Petition), which will be considered upon the final resolution of the claim.


Herman E. Lightsey, Jr., Deputy Commissioner,
For the Chairman.
S. C. Workers' Compensation Commission

Date: 11/14/55
Columbia, S.C.

(578)

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715

WCC File # 9503744
Carrier File #
Carrier Code #
Employer FEIN

GERTRUDE SHIVER 249-98-2546
Claimant's Name SSN
411 Meeting St., # 4309, Chas., SC 29403
Address City State Zip
(803) 577-2904
Home Phone # Work Phone #

TRIDENT REGIONAL MEDICAL CENTER
Employer's Name

9330 Medical Plaza Dr., Chas., SC 29406
Address City State Zip

ALEXSIS INSURANCE
Insurance Carrier

THOMAS M. WHITE, ESQUIRE
Preparer's Name

(803) 572-0700
Phone #

Complete each information blank. To request a hearing, check box 13. b., indicate the kind of benefits claimed by checking the box(es) at lines 6, 7, and 8 and file this form in duplicate.

- A claim for workers' compensation benefits is made based on the following grounds:
1. a. The claimant sustained an accidental injury to the right shoulder, chest, back, arm & feet on 1/23/95 in Charleston County, State of SC.
 1. b. Describe briefly how the accident occurred Claimant fell while at work.
 2. Both the employee and the employer were subject to the South Carolina Workers' Compensation Act at the time of the injury.
 3. The relationship of employer and employee existed at the time of the injury.
 4. At the time of the injury the employee was performing services arising out of and in the course of employment.
 5. Notice of the accidental injury was given to the employer on 1/23/95 in the following manner: Supervisor was aware of the fall
 - [X] 6. Due to injury, the claimant is in need of (check one):
[] (a) medical examination and treatment for
[X] (b) additional medical examination and treatment for right arm, shoulder, back, chest and feet
 - [X] 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: TO BE DETERMINED
 - [X] 8. Due to the injury, the claimant has permanent disability of the following nature and extent: (check one)
[] (1) General Disability: [] Total [X] (2) Specific Disability: [] Total
[X] Partial
Body part(s) affected are: Right shoulder & arm, chest, back & feet
 - [X] 9. Due to the injury, the claimant has a serious body disfigurement consisting of None
 10. a. At the time of the injury, the claimant was paid weekly wages of \$775.00; and demands accounting of days worked and wages earned as provided by law.
 10. b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident. Trident Regional Medical Center
 11. a. Further grounds of claim: All allowable - Employer/Carrier has refused to provide benefits to Claimant even though they had previously provided authorized medical treatment.
 11. b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident: Dr. Cook & Dr. Andrews, Charleston, SC
 11. c. To the best of your knowledge, did you have any prior permanent disability? If yes, describe: None
 12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
 - [] 13. a. I am filing a claim. I am not requesting a hearing at this time.
 - [X] 13. b. I am requesting a hearing.

[Signature]
Signature of Claimant/Representative

FEB 28

February 23, 1995
Date

Refer to R. 67-205, R.67-206, R.67-207, and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department.

(579)

South Carolina Workers Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715

WCC File #
Carrier File #
Carrier Code #
Employer FEIN

9503744

GERTRUDE SHIVER
Claimant's Name

249-98-2546
SSN

411 Meeting St., # 4309, Chas., SC 29403
Address City State Zip

(803) 577-2904
Home Phone #

()
Work Phone #

THOMAS M. WHITE, ESQUIRE
Preparer's Name

TRIDENT REGIONAL MEDICAL CENTER
Employer's Name

9330 Medical Plaza Dr., Chas., SC 29406
Address City State Zip

ALEXSIS INSURANCE
Insurance Carrier

(803) 572-0700
Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

1. Date of accident: 1/23/95
2. AWW: \$ 753.94 Comp. Rate: \$ 422.48
3. Type of injury: Right arm and shoulder, cervical spine, feet
4. Facts in controversy: The correct amount of Claimant's average weekly wage and applicable compensation rate; amount of temporary total to which Claimant is entitled; whether Claimant has reached maximum medical improvement, and, if so, the amount of loss of use and disability to the Claimant; whether Claimant needs additional medical treatment
5. Legal issues involved: None other than those listed above
6. Unusual problems: None
7. Lay witnesses: Tim Crosand - co-worker who can testify as to Claimant's accident
8. Exhibits: 1994 tax returns and W-2 forms from Chas. Memorial Hospital & Trident Hospital; Letter from Alexsis Insurance dated 2/14/95
9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance) SEE ATTACHED LIST
10. Name, address, and specialty, if any, of the treating physician: Dr. Cook, Dr. Bowles, Dr. Crouch, Charleston, SC
11. Impairment rating(s); body part(s); physician and date of opinion: PREMATURE - Claimant still needs medical care

I certify that I have served this document pursuant to R.67-212 by delivering a copy to E. Douglas Pratt-Thomas, Esquire, at P.O. Drawer O, Charleston, SC, 29402, on the 29 day of July, 1995, by first-class mail.

Signature

On behalf of ☒ Claimant ☐ Employer

July 20, 1995
Date

HEARING DATE: August 11, 1995

File this form and proof of service on the opposing party according to R.67-611 and R.67-212.

WCC Form # 58. Rev. Date 9/90

Pre-Hearing Brief.

(580)

ORDER

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

ppp
BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 9503744

Employee: GERTRUDE SHIVER Employer: TRIDENT REGIONAL MEDICAL CENTER

Carrier: CONTINENTAL INSURANCE COMPANY

☒ The hearing in this matter was not held because:

- ☐ Claimant and/or claimant's attorney ☐ Defense attorney was unable to appear
for ☐ legal ☐ non-legal reasons;
☐ Appointment of Guardian ad Litem is necessary;
☐ Claimant desires an opportunity to retain counsel;
☐ The hearing is premature due to need for additional discovery;
☒ Form 50 or 52 voluntarily withdrawn;
☐ Form ☐ 15, ☐ 16, or ☐ Agreement and Final Release (put on the record) proposed for voluntary
settlement of the claim;

IS ORDERED THAT:

- ☐ This file be retained in the Commissioner's office awaiting receipt for approval of settlement.
☐ This file be returned to the Judicial Department and rescheduled for hearing on or before _____.
☒ This file be returned to central files and rescheduled for hearing upon request of either party.
☐ Claimant referred for evaluation to Dr. _____ pursuant to 42-15-80.
☐ Fines _____

☐ This claim was heard before the undersigned Commissioner. The issues have been heard and the following
decision rendered.

- a. ☐ The record is closed.
b. ☐ The record shall remain open for _____ days from the date of this order for purposes of filing:
☐ deposition of _____
☐ medical report of _____ ☐ other _____
c. ☐ Settlement agreement put on the record.
d. ☐ _____

IS ORDERED THAT:

Counsel for the ☐ Claimant ☐ Employer/Carrier shall file in this Commissioner's office and serve all
parties a proposed order within _____ days of the date of this Order. (If counsel is unable to file and serve a
proposed order within the period set forth above, please contact this Commissioner's office.)

Ms. Gertrude Shiver *(E) ref. mail*
Mr. E. Douglas Pratt-Thomas

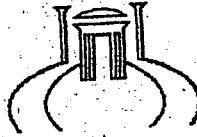
Ann Miller

Commissioner
(5811)

PRATT-THOMAS, PEARCE, EPTING & WALKER

E. DOUGLAS PRATT-THOMAS
W. GREGORY PEARCE
ANDREW K. EPTING, JR.
G. TRENHOLM WALKER
W. ANDREW GOWDER, JR.
JON L. AUSTEN
ALLISON MOLONY CARTER
THOMAS H. HESSE (SC & GA)

SEAN K. TRUNDY
JOHNNIE W. BAXLEY III
DERWIN T. BRANNON
I. KEITH MCCARTY (SC & TN)
LINDSAY K. SMITH-YANCEY (SC & NC)
MATTHEW D. HAMRICK
WILSON W. McDONALD



PROFESSIONAL
ASSOCIATION

ATTORNEYS AT LAW

18 CHARLOTTE STREET
CHARLESTON, SC 29403

P.O. DRAWER 22247
CHARLESTON, SC 29413-2247

TELEPHONE: (843) 727-2200
FAX: (843) 727-2238

<http://www.wiselaw.com>

April 20, 2000

The Honorable Ann McCrowey Mickle
S.C. Workers' Compensation Commission
1612 Marion Street
P.O. Box 1715
Columbia, SC 29202-1715

RE: Employer: Trident Regional Medical Center
Employee: Gertrude Shiver
Carrier: Alexsis Risk Management Services
D/A: 1/23/95 WCC File#: 9503744
Carrier File#: 47893
Our File#: 383-125

Dear Commissioner Mickle:

As you will recall I represent the Employer and Carrier in the above-referenced workers' compensation claim and this matter was, of course, set for a hearing on 4/12/00 here in Charleston. As you will recall at that time you had a long discussion with Ms. Shiver advising her of her options and as I understand it Ms. Shiver decided to withdraw her Form 50, with leave to refile if she so desires in the future. As such, the hearing did not take place.

At that time you also discussed with Ms. Shiver the possibility of resolving this claim and her outstanding 1997 claim with the Employer on a clincher if my clients were indeed interested in making an offer in the range of \$7,604.64, in return for a full release of all claimed injuries in her 1995 accident, as well as releasing any claims which may remain in her 1997 claim. Before I had an opportunity to discuss same with my clients, I received the enclosed letter from Ms. Shiver by certified mail. As you will see, it is dated 4/12/00 and, as such, was obviously written the same day as the scheduled hearing. Since Ms. Shiver is not interested in any settlement offer, my clients are not going to make one.

By copy of this letter to Ms. Shiver, I am informing her of the above and of the fact that I am providing to you a copy of her letter to me of 4/12/00.

Under these circumstances, I am assuming the Commission will issue an appropriate form order indicating that Ms. Shiver was allowed to withdraw her Form 50. Should you have any questions or should I need to take any further action, please do not hesitate to contact me.

(582)

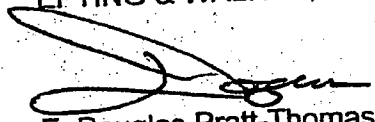
(843) 727-2212 (direct dial)
(843) 727-2239 (direct fax)
dpt@wiselaw.com (e-mail)

The Honorable Ann McCrowey Mickle
April 20, 2000
Pg. 2

With warmest regards, I am,

Sincerely,

PRATT-THOMAS, PEARCE,
EPTING & WALKER, P.A.



E. Douglas Pratt-Thomas

EDP-T:ksl
Enclosure
cc (w/enc.):

Gertrude Shiver, 1100 Congaree Church Road, Gadsden, SC 29052
Mr. Howard A. Levy
David W. Weeks, BSN, MA
Mr. Stan Cobb

(583)

4-12-00

Dear Mr. Pratt - Thoms:

if am not going to accept the \$7000 for
you to clear all of my cases. Just if all it
am not going to settle my claim. You & Thoms
White has already played some dirty tricks on me
several years. Thoms White forced me to sign that
E-signature Order which you and he did present
me have recovered anything by my shoulder and
feet since it did not take the money under the
table that you'll offer me in 1995.

Another thing is that you never paid my doctor
bills in 1994, and it was subsequently reported to the
Credit Bureau. It was only paid once by Dr. McLo,
and never by Dr. Dalton.

You and St. Luke's Hospital are responsible for the
injuries to my feet and shoulder, and I am not making any
hurry up with you to the detriment of myself. If you
didn't have any of my medical records it is because you
didn't want any of them.

Sincerely

Bethel Thoms, Cert. Mail
(584)

RECEIVED
APR 17 2000

CAROLINA EAR NOSE AND THROAT ASSOCIATES, P.A.

110 E. Medical Lane, Suite 220
W. Columbia, SC 29169

Phone: 803-796-8060
FAX: 803-796-6311

James T. Bowles, M.D.

Jacquelyn A. Going, M.D.

Medical Test Request

Patient: Gertrude Shiver Date of test: _____

Where: Lexington Medical Center
Speech Therapy Dept

Type of test: speech therapy

Diagnosis: muscle tension dysphonia

Ordering Physician:

Dr. Bowles

Dr. Going

APR 10 11 10

(585)

South Carolina Workers' Compensation Commission

O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715

WCC File # 0227094
Carrier File # _____
Carrier Code # _____
Employer FEIN _____

PM-11

Gertrude Shiver 249-98-2546
Employee's Name SSN
1026 Congaree
Church Rd. Camden, S. C. 29052
Address City State Zip
(803) 353-3892
Home Phone #
Work Phone #
Gertrude Shiver
Preparer's Name

Palmetto Health Richland
Employer's Name
5 Richland Medical Park Drive
Address City State Zip
Columbia, S.C.
PHTS
Insurance Carrier
Palmetto Health Trust
(803) 353-3892
Phone #

complete each information blank. To request a hearing, check box 13 b., indicate the kinds of benefits claimed by checking the box(es) at lines 6, 7, 8, and 9, and file this form in duplicate.

claim for worker's compensation benefits is made based on the following grounds:

- 1 a. The claimant sustained an accidental injury to left neck, shoulder on 10/24/2002 in Richland County, State of South Carolina
part of body hurt month day year
- 1 b. Describe briefly how the accident occurred See attached sheet
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on 10/24/2002 in the following manner:
month day year
Immediate supervisor notified, Beverly Fulton. Occurance Rpt done
6. Due to injury, the claimant is in need of (check one): N/A
☐ (a) medical examination and treatment for _____
☐ (b) additional medical examination and treatment for _____
7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: None
8. Due to the injury, the claimant has permanent disability of the following nature and extent: (check one)
☐ (1) General Disability: ☐ Total ☐ (2) Specific Disability: ☐ Total ☒ Partial
Body part(s) affected are: Left neck, shoulder See Sheet
9. Due to the injury, the claimant has a serious bodily disfigurement consisting of N/A
- 10 a. At the time of injury, the claimant was paid weekly wages of \$404.005; and demands accounting of days worked and wages earned as provided by law.
- 10 b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident.
N/A
- 11 a. Further grounds of claim: Payment to physicians and providers for care
- 11 b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident: See attached sheet
- 11 c. To the best of your knowledge, did you have any prior permanent disability? yes
If yes, describe: See attached sheet
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
- 13 a. I am filing a claim. I am not requesting a hearing at this time.
- ☒ 13 b. I am requesting a hearing.

Gertrude Shiver
Signature of Claimant/Representative

10-29-06
Date

50
(586)

1 b. On October 24, 2002, I was sitting at Mindy Scarborough's desk working on the computer in the Medical Record Department when the morning supervisor, Jason Morgan, came by with an arm load of charts and put them on the desk. He went and got another arm load of charts and when he got near me, one of the thick heavy charts that contained Neonatal Intensive Care papers fell out of his arms striking me on the left side of my neck and shoulder as it fell to the floor. I immediately felt some pain and I yelled out. This happened around 6:00 p. m. I don't know exactly how many inches thick this chart was, but it was a heavy thick chart. All of the charts that he had put on the desk both times were thick and heavy. I told my evening supervisor, Beverly Fulton, around 6:35 p. m., what had happened and she told me to go to the emergency room.

I didn't go right then to the emergency room because I told Ms. Fulton that the emergency room was crowded and that I wasn't going to get seen. I continued to work on my charts, but as the night progressed, the pain in the left side of my neck and shoulder got worse. When I finally finished up my charts, I put them on the shelf and then I went to the emergency room where I still had to wait a long time before I could be seen because the emergency room was crowded and a trauma patient came to the emergency room. Ms. Fulton was aware that I didn't go to the Emergency Room until I had finished my charts.

8. I have some prior disability to my neck and cervico-thoracic area. I think that I have reached the maximum amount of disability allowed for this type of injury. There is no other new different additional treatment that can be done for my neck that I am aware of. Only, intermittent use of cervical facet and/or trigger point management with focal injections for flare-ups. Also, I have a voice change after this accident, some continued throat pain, and I can't sing like I used to. I don't know for sure if this is a residual effect from the trauma of the thick heavy chart striking me on the left side of my neck and shoulder.

11 b. Palmetto Richland Emergency Room
5 Richland Medical Park Drive
Columbia, S. C. 29203

Jeffrey D. Hook, M.D.
Midlands Internal Medicine
3000 Northeast Medical Park, Suite 108
Columbia, S.C. 29223

Human Performance and Rehabilitation Center
1910 Blanding Street
Columbia, S. C. 29201

RECEIVED

DEC 29 2003

Division of Claims
Claims Administrator
S.C. Workers' Comp. Comm

(581)

Deborah Shure 12-26-03

Page 2

Gregory M. Jones, M. D.
Charleston Spine and Physical Medicine, PA
1930 Charlie Hall Blvd.
Charleston, S. C. 29414

11 c. I had a prior permanent impairment of 3-5% to my cervicothoracic spine from 4/20/97 (MVA) and prior work related injuries. Then an additional 3% for motor vehicle accident of 11/25/2000 for cervical area. This is a total of 8%. Dr. Jones had indicated in his medical notes that, "Although patient does have residual anterior shoulder and left upper chest wall pain and discomfort which has appeared as "new" myofascial injury following 10/24/02 accident on the job, this would require assessment for myofascial pain, and based on recommendations per **AMA Guides to the Evaluation of Permanent Impairment, 5th edition** interpretation, it is inappropriate to add further impairments for this type of injury, particularly when impairments have addressed myofascial injuries in this region previously. Although patient is released today from active care regarding injuries sustained 10/24/02, patient is candidate for intermittent use of cervical facet and/or trigger point management with focal injections for flares. I can address issues regarding future medical care via Life Care Plan if this becomes necessary.

RECEIVED

DEC 29 2003

Division of Claims
Claims Administrator
S.C. Workers' Comp. Comm.

(588)

Denture Shire 1226-05

256
5
NIT RECORD: 009952117
DATE: 10/24/02 23:08
BIRTH DATE: 05/19/54
AGE: 48Y
MOTHER'S MAIDEN NAME: LUCY
SEX: F
MAR: S
RACE: B
PRE REG #: ERR0229701
MIDDLE NAME, PHONE, SOC. SEC.:
52 EMPLOYEES
SKB
10/24/02 18:00
SHIVER, GERTRUDE
1026 CONGAREE CHURCH ROAD (803) 353-9714
GADSDEN SC 29052 249-98-2546
RESPONSIBLE PARTY: SHIVER, GERTRUDE
1026 CONGAREE CHURCH ROAD
GADSDEN SC 29052 (803) 353-9714
CHART FELL ON L SHOULDER
DATE OF LAST VISIT: 07/01/02
MODE OF ARRIVAL: SELF DRIVEN
VALUABLES: ☐ YES ☐ NO WHERE?
BELONGINGS: ☐ HOME ☐ WITH PATIENT OTHER
REQUESTED PHYSICIAN: Present EMS, EMS
With Ref. [Signature]
NURSE'S SIGNATURE: [Signature]
TIME TO TREATMENT: 03:55
LABS AND X-RAY

CHART FELL ON L SHOULDER
DATE OF LAST VISIT: 07/01/02
MODE OF ARRIVAL: SELF DRIVEN
VALUABLES: ☐ YES ☐ NO WHERE?
BELONGINGS: ☐ HOME ☐ WITH PATIENT OTHER
HOSPITAL CARE: ☐ SEE AMBULANCE REPORT ☐ SEE NURSE'S NOTES ☐ EMERGENT ☒ URGENT ☐ NON-URGENT
VITAL SIGNS: TEMP. 97.3°F PULSE 77 RESP. 20 BLOOD PRESS. 136/87
VITAL SIGNS: TEMP. 98°F PULSE 63 RESP. 20 BLOOD PRESS. 120/70
ALLERGIES: codeine, talcum, TB blue
LABS AND X-RAY

TORY: 48y/o at 1800 on 10/24
HOSPITAL CARE: ☐ SEE AMBULANCE REPORT ☐ SEE NURSE'S NOTES ☐ EMERGENT ☒ URGENT ☐ NON-URGENT
VITAL SIGNS: TEMP. 97.3°F PULSE 77 RESP. 20 BLOOD PRESS. 136/87
VITAL SIGNS: TEMP. 98°F PULSE 63 RESP. 20 BLOOD PRESS. 120/70
ALLERGIES: codeine, talcum, TB blue
LABS AND X-RAY

Product 52's, 4 parietal, 4 focal negative
S: LOC, HA, & RIC a/n negative
SH: CH: CVA an
H/MEDS: n/a c chanc, back pain - thoracic disc, staton PRN, nsaids, PRN, Ampicil
H/MEDS: n/a c chanc, back pain, HTN meds: nolic, Tamsin, Cardizem
PHYSICAL: CN: no papilloedema, Aox?

1040385

NICAL REASON: 1) Acute C trapezius strain
TREATMENT:

POSITION/SPECIAL PATIENT INSTRUCTIONS: 1) Diclofenac 75mg PO qid, Advil - sedation precaution
Rest for 48 hours - Heat. Valsartan 24
2) If no improvement in 48 hours - 10mg fentanyl
1) RICE in pain, RIC, away from work in S/S

PATIENT'S SIGNATURE: [Signature]
MEETS PRUDENT LAYPERSON: YES ☒ NO ☐
EDITION OF DISCHARGE: ☒ IMPROVED ☐ OTHER
ADMIT ROOM: 0303
TIME SEEN BY MD: 0303
(589)

Emergency Center at
Almetto Richland Memorial Hospital
NURSING RECORD

Triage Level: 10-24-02
Date: 2300
Time: 2300

Shiver - Gertrude 48/5
Neck Pain/Injury on the
Job NICH
OCT 24 PM 10:56

emp: 97.3 HR: 77 RR: 20 Allergies: clay, latex, blue

IP: 136/83 Pulse Ox: Type of Reaction:
Chief Complaint: phantom feeling of shiver in left arm
movement, turned cap set to left finger

Tetanus: ☐ UTD ☐ Unk
PMH: ☒ HTN ☐ SZ ☐ CAD ☐ DM ☐ RAD ☐ HIV ☐ CVA ☐ CA ☐ Chronic Pain ☐ None
☐ Other pulmonary, herniated disk
☐ Prior Surgeries

Medications: ☐ OTC ☐ Rx ibuprofen, codeine, morphine, meclizine, acid, ASA
☐ Herbal ☐ Stimulants ☐ None

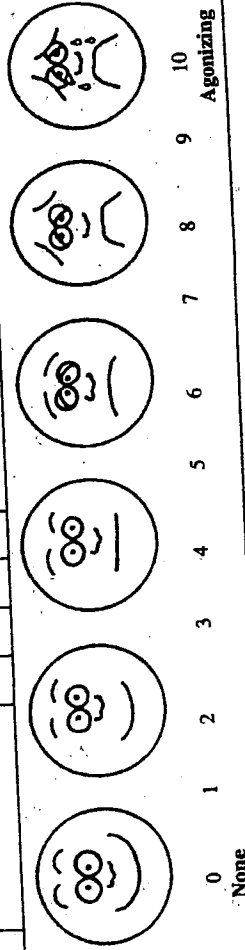
Pain Assessment: ☒ Yes ☐ No Intensity: 7.5 on 10 scale Location: left shoulder
Duration:
When did your pain start?
What words best describe the pain that bothers you the most?
☐ Dull ☒ Aching ☐ Shooting ☐ Burning ☐ Stabbing ☐ Throbbing ☐ Other
What makes your pain worse?
☐ Moving ☐ Heat ☐ Cold ☐ Coughing/Sneezing ☐ Sitting ☐ Lying Down ☐ Eating
☐ Other
What makes your pain better?
☐ Heat ☐ Cold ☐ Lying Down ☐ Medications ☐ Relaxation ☐ Magnet/Herbal Therapy
☐ Other
Does your pain interrupt your sleep? ☐ Yes ☐ No
Is there anything else you wish to tell us about your pain?

Standing Orders: ☐ X-Ray ☐ Labs ☐ CBC ☐ BMP ☐ UA ☐ UPT ☐ FSBS
Prehospital Treatment: ☐ IV ☐ Other
☐ Meds:

Time	Reassessment	T	P	R	BP	P.Ox	Pain Interventions	Interventions	Initials

Barriers: ☐ Motor Impairment ☐ Language Impairment ☐ Speech or Hearing Impairment ☐ Visual Impairment ☐ Other
Interventions: ☐ Interpreter Contacted ☐ Unable to Locate Interpreter ☐ TDD Phone Used ☐ AT&T Operator Used
Physician: Patient Called: ☐ Yes ☐ No
☐ Wants PMD Called ☐ Wants ED MD to Treat
Visual Acuity: *See Assessment
L 20/ Both 20/
R 20/

Triaged to: ☐ Pod 1 ☐ Pod 5 ☐ Trauma Room
☐ Pod 4 ☐ Pod 6 ☐ Pod 7
☐ Waiting Room
What questions/concerns do you have about this visit:
Triage RN:



(5390)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE

July 1, 2003 Patient is seen in follow up. Has fortunately seen good benefit with the injections accomplished in series 6/3/03 (left cervical facet injections, 5 levels) and 6/4/03 (left shoulder girdle and left lateral neck Myobloc chemodenervation). Patient estimates overall about 80% relief. Still feels that she has persisting pain in left anterior chest wall (upper aspect) and left anterior shoulder region which is "new" and related to most recent injury on the job when a group of charts fell onto her neck and shoulder on left side.

- Impression:**
1. Flared left-sided cervicothoracic and shoulder girdle myofascial pain (with flared cervical facet-generated pain concomitant) secondary to work-related contusion to left neck and shoulder region 10/24/02, good relief noted with recent focal injection therapies, now considered at MMI.
 2. History of chronic multifactorial cervicalgia, worse on left, initially symptomatic following injuries 4/20/97 (MVA) and 10/11/97 (work injury) with 5% DRE Category II impairment assessed 7/29/98, followed by additional aggravation of particularly cervical facet injuries in 11/25/00 MVA, with additional 3% impairment assessed 8/13/01, date of MMI.
 3. Chronic, currently stable multifactorial low back pain.

Recommendations/Discussion: There is no change regarding impairment assessed for lumbar pathology in past. Refer to 6/4/03 progress note for details.

As of today's date, we can likely assume Gertie at MMI regarding injuries sustained on the job 10/24/02 due to contusion to left neck and shoulder region with charts. Patient appears to have had flaring of primarily myofascial pain, but also had flaring of cervical facet-generated pain components on left side. Fortunately, patient has gotten significant benefit with treatment directed toward these injuries.

Assuming MMI as of today's date for work injury sustained 3/23/02 to cervical spine and left shoulder girdle, and based on *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*, I can assess no additional impairment for this injury, as previous impairments have been assessed for both myofascial and cervical facet-generated pain, which was present in this patient to great extent even prior to 10/24/02 injury on the job. Although patient does have residual anterior shoulder and left upper chest wall pain and discomfort which has appeared as "new" myofascial injury following 10/24/02 accident on the job, this would require assessment for myofascial pain, and based on recommendations per *AMA Guides to the Evaluation of Permanent Impairment, 5th edition* interpretation, it is inappropriate to add further impairments for this type of injury, particularly when impairments have addressed myofascial injuries in this region previously.

Patient had majority of injuries that have resulted in additional impairment cervical spine occurring on 11/25/00. This not only flared neck pain (particularly cervical facet-generated pain component), but also significantly flared multifactorial low back symptoms. Assessments for impairments (where necessary) have already been addressed in regard to these various injuries sustained 11/25/00.

Although patient is released today from active care regarding injuries sustained 10/24/02, patient is candidate for intermittent use of cervical facet and/or trigger point management with focal injections for flares. I can address issues regarding future medical care via Life Care Plan if this becomes necessary. Patient to continue with home exercise protocol life-long. Patient would also benefit from regular aerobic activity at least 3x weekly. Patient is allowed to continue with usual duties, as her work site requirements are primarily for sedentary work at desk/computer, where she is in health information management, working in Columbia for Palmetto Richland Memorial Hospital. There have been no additional restrictions regarding this patient relating to work injury 10/24/02. Follow up hereafter prn.

Gregory M. Jones, M. D.

GMI/bjl

cc: Palmetto Health Trust
Attn: Lori Sharpe

(594)

APA 15

October 9, 2006

RE: WWW#0322274

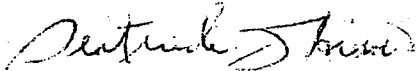
Dear Sir:

This is a refiling of my original claim dated 12/26/03 where I am now asking for a hearing. PHTS has not paid any of my doctor bills. I have no legal representation.

On October 6, 2006, I was fired from my job at Palmetto Health Richland because of my book entitled, "The Fall of a Nurse: What is wrong with Gerly." I was accused of derogatory and slanderous references to Palmetto Richland, employees, and physicians. Therefore, I was terminated from employment which left me without any medical insurance and no way to pay on my medical bills.

I am now requesting a hearing without an attorney because the attorneys will not help me. I am trying to avoid filing for bankruptcy. I am enclosing the original correspondence that was filed with my first claims of 12/26/03. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

(592)

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715

WCC File # 0322214
Carrier File #
Carrier Code #
Employer FEIN

Gertrude Shiver 249-98-2546
Claimant's Name SSN
1026 Congaree Gadsden, S.C. 29052
Church Rd. City State Zip
(803) 353-3892 (803) 434-2045
Home Phone # Work Phone #
Gertrude Shiver
Preparer's Name

Palmetto Health Richland
Employer's Name
5 Medical Park Drive Columbia, S.C.
Address City State Zip 292
Palmetto Health Trust
Insurance Carrier
(803) 353-3892
Phone #

Complete each information blank. To request a hearing, check box 13 b., indicate the kinds of benefits claimed checking the box(es) at lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for worker's compensation benefits is made based on the following grounds:

- 1a. The claimant sustained an accidental injury to See attached sheet on 1/21/03 in Richland County, State of South Carolina
part of body hurt month day year
- 1b. Describe briefly how the accident occurred Fell on a waxy floor when my left foot went out from under me as I was trying to go to the time clock.
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on 1/21/03 in the following manner
month day year
Nsg Supervisor Mary Sas notified Occurrence report filled out on 1/22/03.
- ☐ 6. Due to injury, the claimant is in need of (check one): Unknown at present
☐ (a) medical examination and treatment for
☐ (b) additional medical examination and treatment for
- ☐ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work & wages for the period of: none.
- ☐ 8. Due to the injury, the claimant has permanent disability of the following nature and extent: (check one) Unknown.
☐ (1) General Disability: ☐ Total ☐ (2) Specific Disability: ☐ Total
☐ Partial ☐ Partial
Body part(s) affected are: neck, back, side, and all body, lt. leg, wrists, feet.
- ☐ 9. Due to the injury, the claimant has a serious bodily disfigurement consisting of NA
- 10a. At the time of injury, the claimant was paid weekly wages of \$412.40; and demands accounting days worked and wages earned as provided by law.
- 10b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident.
None others except Palmetto Health Richland.
- 11a. Further grounds of claim: Payment to physicians and providers for care.
Compensation for humiliation.
- 11b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident See attached sheet
- 11c. To the best of your knowledge, did you have any prior permanent disability? To my neck, back, and
If yes, describe: Cervico-thoracic area.
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
- ☐ 13a. I am filing a claim. I am not requesting a hearing at this time.
- ☒ 13b. I am requesting a hearing.

Gertrude Shiver
Signature of Claimant/Representative

SCWCC

OCT 10 2006

JUDICIAL

10-7-06
Date

Refer to R.67-205, R.67-206, R.67-207, and R.67-601 through R.67-615. Questions about the use of this form may be directed the Commission's Judicial Department.

WCC Form # 50 Rev. Date 9/90

Employee's Notice of Claim and/or Request for Hearing

50
(593)

ADDENDUM TO WCC FILE #0322274
DOA 1/21/03

10b. Kmart Stores
4400 Fort Jackson Blvd.
Columbia, S. C. 29209

Target Stores
6090 Garners Ferry Rd.
Columbia, S. C.

11a. Reimbursement to Blue Cross and Blue Shield and all providers and physicians for care. Reimbursement to me for approximately \$1,680.15 for my payment of care. I reserve the right to amend this figure if necessary.

Compensation for humiliation and emotional distress. Ms. Holland and Ms. Sullivan wouldn't let me leave HealthWorks to go to Baptist Hospital to have an X-ray done that my physician had ordered.

I was falsely accused of seeking drugs and using alcohol. I was placed on suspension for a week.

I was fired from my job on October 6, 2006. I only work at Kmart for 15 hrs/week at \$6.50 an hour without any benefits. This was the only place that would hire me. I need a desk job and I don't need to be on my feet for a very long period of time. My Cobra Insurance will run out in September 2007 and I won't have any insurance coverage for continued care for flare-ups in my conditions. I am having some flare-up now. My unemployment benefits ran out in May of 2007. The job at Kmart is the only one that I could find and it is the only source of income that I have which is really nothing. Mr. Gregory claimed he fired me because of my book, but I was under worker's compensation with a wrist injury at the time of my firing. I am going to need help in relocating to another state to find a decent job in my field of study.

I need help in going to law school.

SCV

JUL 29 2007

JUDICIAL

DS 7-6-01

(594)

**WORKER'S COMPENSATION ACCIDENT OF 1/21/03. NO WCC FILE
NUMBER KNOWN.**

1 a. neck, back, left side, left leg and foot, both wrists and hands, feet, perineum area, lower abdomen, and all of body. I fell on a hard waxy floor and my body hit the floor in its entirety except my head.

1 b. On January 21, 2003, as I was going from the right side of the hall to the left side of the hall in front of the Medical Record Department at Palmetto Health Richland, my left foot went out from under me and I fell on the hard waxy floor. The housekeepers had the wet sign in the middle of the hall, but both sides of the hall was wet. There was some other people traveling on the left side of the hall. I was trying to reach the time clock to punch out on time because my manager had already gotten after me about having overtime.

11b. Palmetto Baptist Emergency Room
Taylor At Marion
Columbia, S. C. 29220

Jeffrey D. Hook, M. D.
Midlands Internal Medicine
3000 Northeast Medical Park, Suite 108
Columbia, S. C. 29223

Pitts Radiology Associates
1136 Washington Street
Columbia, S. C.

Carolina Medical Imaging
3010 Farrow Rd., Suite 100
Columbia, S. C. 29203

Debra Shum 12-9-03
Debra Shum 12-26-03

(595)

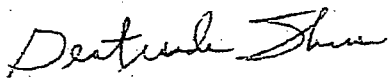
Page 2

continued with my appointments and treatments with my specialist until he turned me loose.

At HealthWorks at Palmetto Health Richland, I have only seen the occupational health nurses and the nurse practitioners. Even though they have the title of "Nurse Practitioners," they are still nurses. I have some prior disability and these nurses couldn't take care of me. Then, there is Dr. Martin Durkin, the neurologist, who is the Medical Director of HealthWorks. He only comes there for a few hours in the mornings on Wednesdays and he haven't shown me that his medical practice is up to par. I have not seen any other physicians there providing care at HealthWorks.

It has been well over a year now and PHTS has not paid anything toward my specialist bill or any of my other medical bills that I know of, nor have they answered my correspondences. Because of these Worker's Compensation Laws in the State of South Carolina, there is nothing legally I can do against Jason Morgan, the white supervisor who dropped the heavy thick chart on my neck and shoulder, nor can I make him pay for the treatments to my neck and shoulder. I have already suffered enough under the Worker's Compensation Laws of this state and I need some relief. Every time that I try to minimize some of my suffering, I always run into one obstacle or another whether it is the law or not. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

(596)

Carolina Workers' Compensation Commission
Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 0322274

Carrier File #

Carrier Code #

Employer FEIN

Gertrude Shiver

1026 Congaree Church Rd.

Gadsden, S. C.

Address

City

State

29052

Zip

(803) 353-3892

Home Phone #

Work Phone #

Palmetto Health Richland

5 Medical Park Drive

Columbia

City

S. C. 29202

State

Palmetto Health Trust

Insurance Carrier

Gertrude Shiver

Preparer's Name

(803) 353-3892

Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.
☐ Injury by Accident ☐ Occupational Disease ☐ Both Injury by Accident and Disease ☐ Other

1. Date of accident 1/21/03

2. AWW:

Comp. Rate:

3. Type of injury and body part(s) neck, back, left side, left leg & foot, both wrists & hands. see attached sheet.

4. Facts in controversy: Was this fall a compensatory injury?

5. Legal issues involved: See attached sheet.

6. Unusual problems: See attached sheet.

7. Witnesses (designate if expert)* I did not get the name of the house keeping staff involved. An employee from the lab took me to the basement and the incident was reported to their supervisor.

8. Exhibits: none.

9. Medical evidence: (indicate report pursuant to R.67-612; deposition or appearance)
Appearance.

10. Name, address, and specialty, if any, of the treating physician: I only went to Baptist ER and Dr. Hook.

1. Impairment rating(s); body part(s); physician and date of opinion: None given.

SIGNATURE Gertrude Shiver 7-6-07

DATE OF HEARING:

on behalf of ☐ Claimant ☐ Employer

SCWCC

TIME OF HEARING:

This form and proof of service on the opposing party according to R.67-611 and the Commissioners reserve the right to admit expert witnesses at hearings. Do not send medical reports.

FORM # 58

REV. 1-01

(597)

ATTACHMENT TO WCC FILE #0322274

4. There is no way that I can prove continued pain in the vaginal, perineum, and lower abdominal area.
5. Under the Nurse Practice Act, are the nurse practitioners taking care of the injured workers under worker's compensation at Health Works considered independent practitioners?

Should the nurse practitioners taking care of the injured worker under workers' compensation at Health works be independent contractors under the Worker's Compensation Laws and the Nurse Practice Act of South Carolina?

What type and schedule of narcotics were the nurse practitioners allowed to prescribe for the injured worker under the Nurse Practice Act at the time of this accident?

Should the Medical Director over Health Works be assigned to take care of the injured worker under worker's compensation?

Is the occupational health nurse and health information manager allowed to keep the injured worker at health works against her will?

Does the nurse practitioner take precedent over the physician in taking care of the injured worker?
6. This accident happened in the night around 12:30 a.m. The nursing supervisor Mary Sas violated their own worker's compensation injury policy by not sending me to the emergency room that night to be evaluated.

In addition, I had already had some problems with the nurse practitioner Coleen Collins and Barbara Griffin, the occupational health nurse with my injury of 11/15/2001. Furthermore, Dr. Durkin, the neurologist and the director of health works, was taking care of me with an orthopedic injury and there were some questions as to his competency. Upon the instruction of the nursing supervisors, Mrs. Scaglione and Mrs. Lenora Bell, I called over to health work to speak with the nurse practitioner Mrs. Mary Kay Parham on Wednesday morning, January 22, 2003. She was not at work that day and she did not returned until Friday, January 24, 2003.

I was told on Friday, January 24, 2003, by the nurse practitioner Mrs. Parham to go to my own physician with the problems that I was having. The problems that I was having came from the fall. I went to my own doctor as she instructed me to

JUDICIAL

13 7-667

(598)

2
do. Palmetto Health Richland didn't offer me any physician for care, only a nurse practitioner even though they were well aware of my documented disabilities.

PHTS claims that they didn't know what happened to me. I went to my own doctor as Mrs. Parham instructed me to. In addition, Mrs. Parham tried to get me fired from my job by Ms. Annette Sullivan. As a matter of fact, I was placed on suspension for a week until the results of my urine test came back. I was accused of seeking narcotics and using alcohol. Since Mrs. Parham had tried to get me fired, I didn't go around her seeking for any care.

Ms. Annette Sullivan and Mrs. Elizabeth Holland had humiliated me during the time when I had to submit to a urine drug screen and at the time that I was trying to do the breathalyzer test for alcohol. Events of the incident is included with Form 50.

I continue at present to have pain in the vaginal, perineum, and lower abdominal area.

The General Assembly didn't assign a monetary value to the tendons, ligaments, and joints of the human body.

The emergency room physician over at Baptist Hospital had told me on a prior occasion not to go back over to Health work. In addition, I had had some prior problems with the nurse practitioner taking care of me with an orthopedic injury.

The nurse practitioner, Ms. Mary Kay Parham told me to go to my own physician for care.

I was only offered a nurse practitioner for care at Health Works.

11. No impairment rating is given for continued pain in the vaginal, perineum, and lower abdominal area. There is no impairment rating with problems with the ligaments, tendons, and joints.

P) 7-6-07

SEY-22
JUL 29 2007
JUDICIAL

(599)

December 26, 2003

Worker's Compensation Injury of January 21, 2003. No WCC File Number given by Palmetto Health Trust Services, the worker's compensation carrier for Palmetto Health Richland.

Dear Sir:

On January 21, 2003, around 12:30 a.m., I fell at Palmetto Health Richland on a hard waxy floor when my left foot went out from under me. Since management at my place of employment was already angry with me because they said that I was not following their worker's compensation policy and procedure with the accident of October 24, 2002, when I went to the emergency room at Palmetto Health Richland, I followed the policy and call the night Nursing Supervisor Mary Sas around 12:45 a. m., and notified her of the fall and the circumstances behind the fall. She stated that she was very busy with a situation upstairs and she could not come. She asked me was I hurt. I told her that I didn't know, but that I had fallen and the whole floor was wet. She did not follow their policy and procedure and told me to go to the emergency room that night to get seen. Instead, she told me when I came back to work the next day that she would leave the accident report and a note with the evening supervisor and that I must go by the office and fill out the form.

I went to work the next day in the Medical Record Department until the nursing supervisor, Pam Schglione called and told me to come to the office and fill out the form. She instructed me to let her know if during the night if I had anymore problems because my whole body was hurting. Around 11:10 p. m. that night, I went back to the nursing supervisor's office where I spoke with Ms. Schglione and Mrs. Lenora Bell because my body still hurt all over and the pain in my perineum area was getting worst. I was instructed to call Ms. Mary Kay Parham that Wednesday morning and talk with her because I had already had a bad experience with Dr. Durkin, Coleen Collins, the nurse practitioner, and Barbara Griffin, the occupational health nurse over at HealthWorks. Also, I had had a bad experience with Dr. Beldin, the orthopedist whom they sent me to.

(600)

When I called HealthWorks on Wednesday morning, January 22, 2003, Ms. Parham wasn't there and I was told by one of the employees that she would not be in the office until Friday, January 24, 2003.

Around 11 a. m., on January 24, 2003, I got up and called Ms. Parham. Someone else in the office who said she was the coordinator of worker's compensation spoke to me. She said, "You didn't go to the ER." I replied, "The nursing supervisor didn't tell me to go to the ER. I want to speak to Ms. Parham because the nursing supervisors told me to speak specifically to her. She replied, "I'll go and get her." Ms. Parham said to me over the telephone, "What do you want Ms. Shiver." I replied, "Are you all still working under Dr. Durkin or is there another doctor working over there?" Ms. Parham stated, "I am an independent practitioner. If I have a question, I will ask another nurse practitioner or call a physician. Dr. Durkin is only the medical director and I will tell Jim Lathern that." Then I asked, "What kind of medication can you order?" Ms. Parham replied, "I can order Motrin, Naprosyn, and other medications like that." "Can you order any narcotics?" Ms. Parham said in an angry voice, "No, we are not allowed to order narcotics." I said, "I can buy motrin over the counter and I am not supposed to take Naprosyn because I have had two esophageal dilatations in the past. Naprosyn doesn't work for me." Ms. Parham said, "Gertrude, I don't have time to talk to you about narcotics over the phone and I haven't seen you yet. What problems are you having that is worker's comp. related." I replied, "My whole body is hurting, I have left sided pain, I am nauseated and having dry heaves, and my perineum hurts. The doctor in the ER ordered some narcotics and flexeril when I was last injured." Ms. Parham replied, "Ms. Shiver, if you are having other problems, you need to see your own physician." "Okay, I will tell him about the other problems that I am having, too." After this, Ms. Parham hung up the phone.

Around 1:15 p.m., on January 24, 2003, I received a telephone call from Ms. Annette Sullivan, the manager from the Medical Record Department. She sounded angry over the phone. "I need you to come in here around 2 O'clock, can you come." I replied, "I will try. I'm still in bed and I have to wash up and get dressed. Is this about the fall?" Ms. Sullivan said, "Yes, and I need to talk to you about it that's all." Around 1:30 p.m., I called Ms. Sullivan back and told her that I couldn't come that I had to go to Palmetto Baptist and have some X-rays done. She still insisted that I come to the office. It was after 3 p. m., when I arrived to the office and she handed me a disciplinary action report. She told me that I had to sign it or that I couldn't work. Then she told me that she didn't want to hear anything from me. In the meantime, she had gone outside and gotten Jason Morgan, the white supervisor who had dropped the heavy chart on the left side of my neck and shoulder. I told her that I wasn't going to sign the disciplinary action report so I had to make a statement on the back. The staff at HealthWorks had made up some accusations on me, and they along with the management in the Medical Record Department had accused me of seeking narcotics and using alcohol. I don't drink alcohol

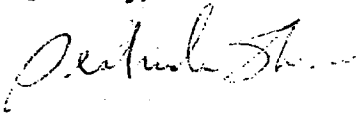
(601)

or beer, and neither do I do drugs. I had needed something for pain with a previous injury, and I didn't received anything.

Afterward, Ms. Sullivan and Mr. Morgan marched me over to HealthWorks where I had to submit to a urine drug screen test after trying to do the breath analysis test for alcohol. Even though I tried many times, I was unable to do blow enough air to do the breath analysis test. I was still sick with the hoarseness and throat pain that I had gotten on December 25, 2002, and my voice had not returned yet. Even though I told the occupational health nurse, Ms. Elizabeth Holland, and Ms. Sullivan that I had to go to Palmetto Baptist and get some X-rays done, I was told that I couldn't leave until I had performed the breath analysis test. I never was able to blow enough air to perform the test, though. Since I couldn't do the breath analysis test, they humiliated me by telling me that I had to catch a taxi home or have someone pick me up since I was under suspicion for narcotics and alcohol. I had to sign a statement that I release Palmetto Health Richland from all liabilities before they would let me go so that I could get my X-Rays done at Palmetto Health Baptist. After this, Ms. Sullivan told me that I couldn't come back to work until she told me to.

On Friday, January 31, 2003, around 4:30 p. m., Ms. Sullivan called and stated that my urine test was negative. I could return to work Saturday or Monday and that she would pay me for the days that I was off and that none of my paid time off days would be used. Since I was on probation and for fear of some other repercussion, I went back to work on Saturday, February 1, 2003, even though my body wasn't really up to it. Although I was paid for the days that I was barred from returning to work, this still has not taken away the continued humiliation and suffering that I am still enduring. In addition, I never did hear anything or received a letter from their worker's compensation carrier PHTS notifying me of my worker's compensation number although it has been nearly a year. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

(602) 6

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9503744

Carrier File # 938481

Carrier Code #

Employer FEIN

Gertrude Shiver	249-98-2546	Trident Regional Medical Center	
Claimant's Name	SSN	Employer's Name	
1026 Congaree Church Road, Gadsden, SC 29052		9330 Medical Plaza Drive, North Charleston, SC 29406	
Address	City	State	Zip
(803) 353-3892		Zurich American Insurance Company	
Home Phone	Work Phone	Insurance Carrier	
Allison M. Carter	421 Wando Park Boulevard, Suite 100, Mount Pleasant, SC 29464	(843) 284-1083	
Preparer's Name	Address	Phone #	

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
GERTRUDE SHIVER, ESQUIRE, ATTORNEY FOR CLAIMANT

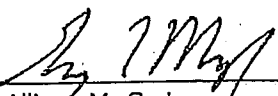
YOU ARE HEREBY NOTIFIED THAT DEFENDANTS, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330, (1976, as amended), herewith submits the following medical reports as direct evidence on behalf of the defendants, to wit:

<u>NAME OF PHYSICIAN/OTHER</u>	<u>DATE OF REPORT</u>	<u>PAGE</u>
APA (1) Ashley River OB/GYN	02/14/95 – 07/31/95	1 – 7
APA (2) James McCoy, MD	08/10/95	8
APA (3) Jeffrey D. Hook, MD	02/12/03 – 09/03/03	9 – 21
APA (4) Gregory M. Jones, MD	06/10/02 – 07/01/03	22 – 38
Exhibit (A) Consent Order	08/24/95	39 – 41
Exhibit (B) Form 15	08/22/95	42
Exhibit (C) Form 17	08/22/95	43
Exhibit (D) Deposition Transcript of Gertrude Shiver	05/31/95	44 – 71
Exhibit (E) Deposition Transcript of Gertrude Shiver	08/24/07	To be submitted

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the depositions of any of the physicians, whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into the evidence on behalf of the employer-defendant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the defendants: See Pre-Hearing Brief.


Allison M. Carter
Willson Jones Carter & Baxley, P.A.
421 Wando Park Boulevard, Suite 100
Mount Pleasant, SC 29464

(603)

August 24, 2007

September 4, 2007
(hearing date)

DATE 2/4/95 AGE 40 WT _____ BP _____ LMP 1/10/94 GON _____
MAMM 12/94 LPR 12/94 URINE 5 sugars 4/0
fell on the job - having vaginal pain
11/23 (3rd fall in 6mo). low pt fibroid
total size 16cm

02/14/95

SHIVER, GERTRUDE

The patient comes in today complaining of lower abdominal pain. This she relates to a fall on January 23, 1995. She also has some back and ankle pain.

PHYSICAL EXAMINATION: The abdomen is somewhat tender. There is a suprapubic mass palpable. On pelvic examination she has what feels to be an approximately 16 week size pelvic abdominal mass consistent with uterine myomas. Although this was not appreciated as being this large when seen in December, there is no question about the enlargement. Ultrasound evaluation today with a nonfilled bladder reveals a single myoma approximately 9 cm and girth of the uterus 11 cm. This is quite a bit larger when she was scanned prior in 1993.

PLAN: I feel the abdominal pain is secondary to enlarging uterine myomas. I have discussed this with Gertie and feel that the options would be to deal with the pain, obviously this is not her interest at this time, myomectomy to preserve fertility or a hysterectomy. The patient is considering myomectomy and would like to preserve her fertility. I am not comfortable evaluating her back or ankles with respect to her fall and she is seeing an orthopedist for this. I have asked her to consider the possibility of myomectomy and she will let me know how she feels like proceeding.

VJW/sh

(604)

3/3

02/27/95

SHIVER, GERTRUDE

I spoke to the patient today about her fibroids. She was under the impression that I could give her a pill to make the fibroids shrink. I told her that was not the case. Should she not get periods I could give her Provera to bring her periods on, but she has been getting normal periods. Her last one was around February 10. What I described to Gertrude is the fact that the fibroids could not be eliminated or shrunk permanently, but Lupron could be given intramuscularly to decrease the size of the fibroids prior to myomectomy surgery. At the present time Gertrude is now understanding better the plan of action. She has some things that she needs to clear up at work and will call me back when she wishes to schedule the surgery.

VJW/sh

3/31/95 - 3.75 mg Lupron given @ Hip (50)
(605)

03/30/95
SHIVER, GERTIE

The patient comes in today. She is taking her first Depo-Lupron shot to try to shrink her fibroids. I discussed the fact that most of the time one or two injections are all that is necessary to get maximum shrinkage. We will see her in a month and see if this has had any effect on the fibroids. She had a blister like lesion on her right breast. I am not sure of the etiology but it seems to be healing. I will see her in four weeks for follow-up.

VJW/dr

5/1/95 Depo-Lupron 3.75 mg. given @ hip (1K)

(606)

DATE 05/1/95 AGE 4 BP 100/90 LMP CON
MAMM LPR URINE
Hooky/n
crn 116-

ALLERGIC TO:

05/01/95
SHIVER, GERDY
Gertie

The patient comes in today for follow-up after having been on the Lupron for one month. Her fibroids have decreased from perhaps 16 to 14 weeks size and I have given her an additional Lupron injection, but feel that her myomectomy surgery should be scheduled in June after this.

VJW/sh

(607)

DATE 10/2/95 AGE 40 WT BP 130/90 LV apm CON
MAMM LPR 12/94 URINE
Pre-Op

Prostate 20 x 2.
2 lnc 25g 1 hy

ALLERGIC TO:

HAAS

06/02/95

SHIVER, GERTRUDE

The patient comes in today for preoperative evaluation. The uterus is approximately fourteen weeks size. The operation of myomectomy along with risks and complications including bleeding, infection and damage to surrounding structures has been discussed. In addition, Gertie has never been pregnant and there is no guarantee that she will be able to do this in the future although fertility is the reason she is going to have a myomectomy rather than hysterectomy. She is on medication for hypertension and it is well controlled at this time.

VJW/dr

✓

(608)

06/14/95

SHIVER, GERTRUDE

The patient comes in today for follow-up. She had a small area of wound separation in the right side and this will be treated with peroxide. She has been reassured.

VJW/sh

[Handwritten signature]

(609)

MAMM

LPR

ALLERGIC TO:

Lucas - DC U-11-748A

The patient comes in today for postoperative evaluation. She states that she still has significant pain when ambulating and does not feel capable in going back to work. Her abdominal incision is well healed. The uterus is anteverted and normal size, but somewhat difficult to evaluate. Her vagina shows monilia and Monistat has been recommended. I feel that she will be able to go back to work in the next four weeks and will be seen in six months for follow-up to reevaluate her uterine size after her myomectomy.

VJW/sh

(610)

ASHLEY RIVER OB/GYN
1364 ASHLEY RIVER ROAD
CHARLESTON, SOUTH CAROLINA 29407

SANDFORD ESTES, M.D.
TOR J. WEINSTEIN, M.D.
THRYN M. HARGROVE, M.D.
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ATT: ~~Atina~~ 3rd Floor

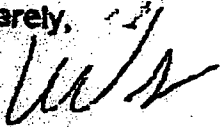
July 31, 1995

Re: Gertie Shiver

To Whom It May Concern:

Gertie has been seen after her surgery for a myomectomy which was done on June 6, 1995. Her return to work at eight weeks postoperatively is appropriate. The date she may return is August 8, 1995.

Sincerely,



Victor J. Weinstein, M. D.

VJW/dr

(611)

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, reflux with overlapping stricture status post dilation and chronic back and neck pain, who basically presents with severe left-sided rib and abdominal discomfort status post fall. The patient notes that on 01/21/03, she actually slipped on a wet floor at work, landing on her left side and rib cage. She had a tremendous amount of discomfort almost immediately. She claims that not only was she having a significant amount of left-sided rib and abdominal discomfort but it also exacerbated her underlying neck and back pain as well. Apparently, the patient was seen by a nursing supervisor who suspected that the patient was seeking narcotics and actually the patient had a breathalyzer test as well. This apparently returned normal. Nonetheless, the patient felt that due to the fact that she had not seen a physician, went to Baptist ER. At that time, she had some rib films which were negative. Due to the fact that she was having abdominal discomfort and actually some suprapubic discomfort as well, a urinalysis was run and she was found to have a urinary tract infection. She was placed on Macrochantin. The patient noted that briefly this seemed to help with some of her discomfort but it has since returned. Again, she claims that associated with this discomfort, she has had some nausea and at one point some vomiting. She has also had some mild loose stool. She denies any fever or chills. She continues to have suprapubic discomfort as well as some peroneal irritation as well. She has been somewhat hesitant to take any Darvocet for the pain due to the fact that she is concerned that a urine drug screen may show narcotics and thus has basically been trying to take care of this pain with heating pads and ice as well as rest. She also notes that she is having some discomfort in her left foot, left knee, left elbow, and left shoulder on the side in which she fell. The patient claims she is quite concerned that no one is taking her complaints seriously. She notes that she feels that there is some internal damage done and this has not been addressed by any of the physicians she has seen thus far. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.

ALLERGIES: Unchanged as previously documented in the chart.

MEDICATIONS: Unchanged as previously documented in the chart.

SOCIAL HISTORY: Unchanged as previously documented in the chart.

FAMILY HISTORY: Unchanged as previously documented in the chart.

(6/2)

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MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

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REVIEW OF MEDICATIONS:

1. Tenormin 25mg bid
2. Cardizem CD 120mg q day
3. Mobic 7.5mg bid
4. Baby aspirin daily
5. Occasional Tylenol
6. Skelaxin and Flexeril prn
7. Occasional Green Tea.

REVIEW OF SYSTEMS: The patient notes that she had to re-institute her Cardizem due to the fact that she was having some mild breakthrough palpitations. She notes that she is having no urinary symptoms at this time and claims that for the most part, her bowels have somewhat regulated, even though they are relatively loose but continues to have some formed products. She denies any rectal bleeding, or dark or tarry stool. The patient denies any abdominal distention but notes, again, severe left-sided discomfort as well as continued suprapubic discomfort. The patient also notes that she is having clear phlegm in her throat that is sometimes hard to clear. She feels that this is likely coming from post nasal drip but wants to have an ENT referral. She really has no other major complaints. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Moderately anxious. In no acute distress.

HEENT: Unremarkable.

NECK: Some left-sided muscular tension, otherwise unremarkable.

LUNGS: Clear.

CARDIOVASCULAR: Regular.

CHEST WALL: There is moderate distal left-sided rib tenderness in the lateral aspect.

ABDOMEN: Obese, soft, moderate diffuse tenderness in the left upper and left lower quadrants, radiating to the suprapubic area. There is no rebound or guarding. There is no hepatosplenomegaly or mass.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

LABS: Urinalysis was run and negative.

(613)

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MIDLANDS INTERNAL MEDICINE

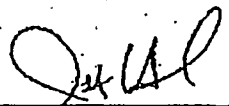
OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

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ASSESSMENT AND PLAN:

1. Diffuse generalized abdominal pain, most notably left-sided and suprapubic, status post fall. Again, I have reassured the patient that I feel that this is likely more musculoskeletal due to her recent fall with bruised ribs and likely an abdominal strain. However, she feels that there is more going on. We will go ahead and obtain abdominal and pelvic CT with and without contrast for further evaluation. In the meantime, we will place the patient on Ultram, which should not turn her drug screen positive, if this is some concern of her place of work. She should continue, obviously, with the Mobic and use the muscle relaxers as needed.
2. Paroxysmal supraventricular tachycardia. Stable once adding her Cardizem back to her regimen. We will continue.
3. Cervical/trapezius strain. Again, the patient has seen The Spine Clinic in Charleston. They basically have recommended physical therapy.
4. Reflux. Stable on Aciphex.
5. Post nasal drip. We will try the patient on Clarinex. We have given her some samples. If she does not see any improvement there, consider nasal inhaled steroids. I do not feel that ENT referral at this time is necessary.
6. Routine health maintenance. Up to date.



Jeffrey D. Hook, MD

(614)

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